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THE UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

JOSEPH RADOSTI Plaintiff, v. METROPOLITAN LIFE INSURANCE COMPANY; and and CITIGROUP LONG TERM DISABILITY PLAN Defendants.	O8 CV 4973 (AKH)(GWG) COMPLAINT

COMES NOW Plaintiff Joseph Radosti ("Radosti" or "Plaintiff"), by his attorneys Scott M. Riemer and Pamela I. Atkins appearing pro hac vice, and files this Complaint alleging that Metropolitan Life Insurance Company ("MetLife"),

Citigroup, Inc. ("CitiGroup"), and Citigroup Long Term Disability Plan ("Plan" or "LTD Plan") (hereinafter collectively referred to as "Defendants") wrongfully and unreasonably denied Radosti's claim for LTD benefits. Radosti's claims arise pursuant to the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), 29 U.S.C. §1001, et seq., seeking to recover benefits due under an employee benefit plan, to clarify the rights of Plaintiff to future benefits under such plan, and to recover attorney fees and costs.

A. JURISDICTION

1. This Court has subject matter jurisdiction pursuant to Section 502(e)(1) of ERISA, 29 U.S.C. §1132(e)(1) and 28 U.S.C. §1331. Under Section 502(f) of ERISA, 29 U.S.C. §1132(f), this Court also has jurisdiction without respect to the amount in controversy or the citizenship of the parties.
2. Venue is proper in the district pursuant to Section 502(e)(2) of ERISA, 29 U.S.C. §1132(e)(2), in that the Plan as hereinafter defined is administered in the district and the defendant resides or may be found in this district.

B. PARTIES

3. Plaintiff Radosti is and was, at all relevant times, a citizen of the United States. Plaintiff resides currently in the State of Kentucky. Plaintiff was an employee of Citigroup, Inc., a company that procured long term disability benefits for its

employees through the Citigroup Long Term Disability Plan. Plaintiff was an eligible employee and a participant in the LTD Plan within the meaning of Section 3(7) of ERISA, 29 U.S.C. §1002(7). Plaintiff is and was, at all relevant times, a beneficiary of the LTD Plan.

4. At all relevant times, the LTD Plan is and has been an "employee welfare benefit plan" within the meaning of Section 3(1) of ERISA, 29 U.S.C. §1002(1). Service of legal process may be made upon: Plan Administrator: Citigroup, Inc., General Counsel, 399 Park Avenue, 3rd Floor, New York, New York 10043

5. At all relevant times, Metropolitan Life Insurance Company ("MetLife") is and has been acting as the de facto plan administrator as defined by ERISA §3(16)(A), although it is not specifically named as the plan administrator or as a named fiduciary of the Plan. Service of legal process may be made upon: Donald J. Harman, Metropolitan Life Insurance Company, One Madison Avenue, New York, New York 10010.

C. FACTUAL BACKGROUND

6. Plaintiff has exhausted all administrative remedies and the matter is ripe for judicial review.

7. The benefits under the Plan were furnished in accordance with and pursuant to

Group Policy No. 1137000-2-G issued by MetLife and in effect at all times relevant hereto in consideration of premiums paid by the Plaintiff. A true and correct copy of the foregoing policy is attached hereto and by that reference incorporated herein as Exhibit "A."

8. Plaintiff Joseph Radosti was employed with Citigroup on September 10, 2001 and ceased worked on September 5, 2002 due to his disabling condition. During and prior to the onset of Radosti's total disability on or about September 5, 2002, his last day at work, he was employed as a Financial Planner with Citigroup.

9. As an employee of Citigroup, Radosti was provided with short term and long term disability insurance coverage under the Plan.

10. With the support of his treating physician, Radosti applied for disability benefits under the Citigroup LTD Plan alleging disability based on the restrictions and limitations associated with Crohn's Disease (Inflammatory Bowel Disease).

11. On September 6, 2002, Radosti was rendered totally disabled within the meaning of the Plan due pain, cramping, diarrhea, fatigue, dizziness and weakness, his need to take unscheduled breaks, his need to lie down, his need for ready access to a bathroom, and his need to take pain medications for his

condition.

12. On or about June 22, 2003, Radosti was awarded Social Security Disability benefits finding him disabled from all substantial, gainful activity as of September 6, 2002.

13. The medical documentation submitted to MetLife supported Radosti's diagnosis of Crohn's Disease (Inflammatory Bowel Disease), and benefits were paid for "Disability" under the policy definition from December 7, 2002 through July 31, 2004.

14. Radosti's LTD claim was approved by MetLife with a disability onset date of September 7, 2002, and a benefit start date of December 7, 2002. A letter documenting the claim approval dated December 30, 2002 was sent by MetLife to Radosti.

15. MetLife terminated Radosti's LTD entitlement as of July 31, 2004.

16. Radosti submitted a timely appeal of MetLife's denial/termination supported by voluminous medical records from an independent medical examination conducted by a neuropsychologist, records and reports from other physicians who had examined Radosti and concluded he was unable to perform his job duties.

17. Although MetLife had a contractual right to have Radosti examined, MetLife

never arranged for or even requested an independent medical examination and relied solely upon non-examining consulting physicians who are frequently retained by MetLife and other insurers who are known to give opinions supporting the denial of benefits. By letter dated June 1, 2005, MetLife denied Radosti's final appeal.

18. Radosti has complied with and exhausted all administrative appeals under the plan.

Terms of the LTD Plan

19. The Long Term Disability Group Policy ("Policy") No. 1137000-2-G Effective January 1, 2002 defines "Disability" as

> **TOTAL DISABILITY**
>
> If you are a member of Class II, "Disabled" or "Disability" means that due to sickness, pregnancy or accidental injury, you are receiving Appropriate Care and Treatment from a Doctor on a continuing basis; and
>
> 1. During your Elimination Period and the next 60 month period, you are *unable to earn more than 80% of your Predisability Earnings* at your Own Occupation, for any employer in your Local Economy; or
> 2. After the 60 month period, you are *unable to earn more than 60% of your Predisability Earnings* from any employer in your Local Economy at any gainful occupation for which you are reasonable qualified taking into account your training, education, experience and Predisability Earnings.

OWN OCCUPATION

"Own Occupation" means the activity that you regularly perform and that serves as your source of income. It is not limited to the specific position you held with your Employer. It may be a similar activity that could be performed with your Employer or any other employer.

20. Radosti was and is disabled within the definition of disability in the LTD Policy and is entitled to benefits.

21. MetLife's determination that Radosti is not totally disabled within the meaning of the Plan is contrary to the terms of the Plan, contrary to the medical evidence, unreasonable, and, under any standard, arbitrary and capricious.

Occupation, Sickness & Request for Review

22. At the onset of disability, Radosti "occupation" as defined in the LTD Policy was that of "financial planner."

23. Radosti's entitlement to continued disability benefits is supported by his treating and examining physicians, the objective medical evidence, the vocational information, and the claim file.

24. Upon information and belief, MetLife requested a Physician Consultant Review by Joseph N. Nesta, MD (hereinafter "Dr. Nesta") dated June 15, 2004.

25. Dr. Nesta did not physically examine Radosti nor did he perform any functional capacity evaluation to determine whether Radosti's physical abilities meet the

requirement of sedentary work.

26. On Radosti's behalf, Dr. Riggs wrote a letter on or about August 31, 2004, to MetLife Disability, which stated, in part:

> I did receive the official consultation from Dr. Joseph Nesta regarding Joseph Radosti's disability request. The consultation was dated 6/15/04. I have discussed the findings with Mr. Radosti and there are some things that need to be readdressed…He reports that he still suffers from exhaustion, dizziness, fatigue, inability to concentrate as well as difficulty with memory. Abdominal pain and breathing pain continues and he reports a weight loss of approximately 60 pounds since his illness began. He was last seen in our office on 6/1/04 and his weight at that time was 127 pounds.
>
> I would ask that you give some reconsideration to his disability request. If you have any further questions or comments, please do not hesitate to contact me.

27. On or about January 24, 2005, counsel, on behalf of Radosti, sent a letter to MetLife requesting a review of the termination of his claim for Long Term Disability benefits.

28. On Radosti's behalf, Dr. Nicholas completed a Psychological Evaluation and Neuropsychological Screening Report dated February 9, and 17, 2005; and a Supplemental Detailed Report of February 18, 2005, stating, in-part, as follows:

> In this Neuropsychologist's clinical experience Mr. Radosti's condition most clearly resembles that of a **Cerebral Hypoxia (ICD-9 Code 3481.1)**. Mr. Radosti did indicate a time of loss of consciousness and a significantly long course of rehabilitation where

> he needed to learn to speak, eat, and walk again. Mr. Radosti's overall cerebral deficits appear to be in the area of problem solving new learning abilities against a background of reduced cognitive efficiency.
>
> Mr. Radosti's probability of returning to work as a Certified Financial Planner is poor at best. The necessary cognitive skills and speed of thinking and ability to communicate with others in an appropriate way would appear to be significantly compromised in Mr. Radosti's case.

29. Upon information and belief, MetLife advised Radosti, through his attorney, via letter dated on or about June 1, 2005 of their continued denial of LTD benefits, and stated "Administrative remedies under the plan have been exhausted, and no further appeals will be considered."

30. On or about February 24, 2005, Dr. Rana completed a Crohn's & Colitus Residual Functional Capacity Questionnaire, setting forth his opinion in-part, indicating the following Diagnosis: Crohn's Disease. Dr. Rana further opined: "Radosti is limited physically and psychologically."

31. On or about June 1, 2005, MetLife upheld its original determination on appeal review, issuing its final denial, and exhausting Radosti's administrative remedies.

32. The LTD Plan determination failed to properly consider the severity, frequency and duration of Ms. Radosti's pain, cramping, diarrhea, fatigue, dizziness and

weakness, his need to take unscheduled breaks, his need to lie down, his need for ready access to a bathroom, and his need to take pain medications for his condition.

33. MetLife's denial letter to Ms. Radosti dated July 28, 2004 and June 1, 2005, completely failed to:

a) Explain and articulate to Radosti the necessary factual and contractual evidence which led them to conclude he was not totally disabled under the Plan;

b) Explain to Radosti that the detailed examinations, evaluations, treatments and conclusions of his treating gastroenterologists, Dr. Riggs and Dr. Rana and treating neuropsychologist, Dr. Nichols, were considered and in what manner; and

c) Explain to Radosti why Dr. Riggs, Dr. Rana and Dr. Nichol's conclusions, did not persuade MetLife that Radosti is totally disabled under the Plan.

34. The LTD Plan denials failed to consider the fully-favorable determination of the Social Security Administration or articulate in any manner how the determination was considered.

35. MetLife's termination of benefits to Radosti is wrong, inconsistent with the evidence of record, without any reasonable basis, arbitrary and capricious.

D. CLAIMS FOR RELIEF

COUNT I

WRONGFUL DENIAL OF LONG TERM DISABILITY PLAN BENEFITS FOR RECOVERY OF PLAN/POLICY BENEFITS PURSUANT TO 29 U.S.C. § 1132(a)(1)(B)

36. Plaintiff Radosti incorporates those allegations of the General Allegations: A. Jurisdiction, B. Parties, C. Factual Background as set forth in all preceding paragraphs above as if set forth in full in this cause of action. The LTD Plan and its administrators wrongfully, unreasonably, arbitrarily and capriciously, and with the taint of self interest terminated Radosti's disability claim. Substantial evidence exists to support a finding of disability in favor of Radosti under the LTD Plan definition of disability.

37. Substantial evidence exists to support a finding that MetLife's denial of benefits under the LTD Plan was wrong, unreasonable, arbitrary and capricious and tainted by self interest.

38. By terminating Radosti's LTD benefits, Defendants violate 29 U.S.C. § 1132(a)(1)(B), ERISA § 502(a)(1)(B).

COUNT II

PENALTY AGAINST DEFENDANT CITIGROUP FOR FAILURE TO PROVIDE DOCUMENTS

PURSUANT TO 29 U.S.C. § 1132 (c)(1)

39. Plaintiff Radosti incorporates the allegations set forth in all preceding paragraphs above as if set forth in full herein.

40. Plaintiff Radosti through counsel made repeated written requests for documents from Defendant Citigroup related to or pertaining to Radosti's LTD claim.

41. Defendant Citigroup failed to properly respond to the requests for documents and failed to provide certain documents to Radosti.

42. Defendant was obligated to provide some, if not all, the documents requested by Radosti.

43. Radosti was harmed by the failure to provide documents.

44. Citigroup was the plan administrator for the LTD Plan.

45. Citigroup had an obligation to provide all the documents required to be provided upon written request by a plan participant under statute and under the Department of Labor's ERISA claims regulations.

46. Administrators have an obligation to provide information including a duty to respond to written requests for information about the employee benefits and the documents relevant to a claim for benefits and participants and

beneficiaries have a cause of action if they do not provide the information.

47. ERISA § 502(c), 29 U.S.C. § 1132(c) provides for penalties for an administrator's refusal to supply required information.

48. This penalty applies to the failure to provide the documents relevant to the plan: "(4) The administrator shall, upon written request of any participant or beneficiary, furnish a copy of the latest updated summary, plan description, and the latest annual report, any terminal report, the bargaining agreement, trust agreement, contract, or ***other instruments under which the plan is established or operated.***" [emphasis added] The administrator may make a reasonable charge to cover the cost of furnishing such complete copies. The Secretary may by regulation prescribe the maximum amount which will constitute a reasonable charge under the preceding sentence. ERISA § 104(b)(4), 29 U.S.C. § 1024(b)(4).

49. In addition to the summary plan descriptions and other documents under which the plan is operated, ERISA § 109(c), 29 U.S.C. § 1029 provides that the Secretary of Labor may also prescribe what other documents should be furnished:

> (c) Format and content of summary plan description, annual report, etc., required to be furnished to plan participants and beneficiaries. The Secretary may prescribe the format and content of the summary plan description, the summary of the annual report described in

> section 1024(b)(3) of this title and ***any other report, statements or documents*** (other than the bargaining agreement, trust agreement, contract, or other instrument under which the plan is established or operated), ***which are required to be furnished or made available to plan participants and beneficiaries receiving benefits under the plan.***
> [emphasis added]

50. Citigroup had an obligation as the plan administrator to provide all the documents relevant to a claim that are required to be provided by the Department of Labor's ERISA claims regulations.

51. Citigroup failed to provide the information requested to be provided under ERISA regulations within 30 days and failed to provide all the information requested that ERISA requires be provided.

52. Radosti claims penalties against defendant Citigroup as the plan administrator for failure to provide documents pursuant to 29 U.S.C. ' 1132 (c)(1) from January 19, 2005 (30 days after the December 20, 2004 request) to the present.

53. Pursuant to 29 U.S.C. ' 1132 (c)(1), defendant Citigroup as the plans administrator is liable for penalties in an amount up to $110.00 per day from January 19, 2005 and for such other relief as the court in its discretion deems proper.

COUNT III

CAUSE OF ACTION FOR REINSTATEMENT TO TERMINATE BENEFITS AND/OR EQUITTABLE RECESSION

54. Plaintiff Radosti incorporates the allegations set forth in all preceding paragraphs above including A. Jurisdiction, B. Parties, C. Statement of the Case, D. Counts I-II as though set forth in full in this cause of action.

55. Against Citigroup, Plan Administrator of the Citigroup Long Term Disability Plan including the Retirement, Medical and Prescription Drug Coverage, Dental, Vision, Basic Life, and Group Universal Life plans to the extent available under 29 U.S.C. δ 1132(A)(1)(B) as a claim or as relief, and to the extent unavailable under (A)(1)(B) as claims or as relief, Radosti requests under (a)(3) that he be restored to the status quo ante for a plan participant who made any voluntary elections based on the wrongful denial of the LTD benefits and that he be put back in the position that he would have been in had his benefits not been wrongfully denied, including the approval, reinstatement, or retroactive reversals or equitable recession of any employee benefits or elections that were made as a result of the denial of LTD benefits.

COUNT IV

ATTORNEYS FEES AND EXPENSES AND COSTS OF LITIGATION PURSUANT TO 29 U.S.C. SECTION 1132(g)(1)

56. Plaintiff Radosti incorporates the allegations set forth in all preceding paragraphs above as if set forth in full herein.

57. 29 U.S.C. § 1132(g)(1) authorizes this Court to award reasonable attorneys' fees and costs of action to either party in an ERISA action.

58. As a result of the actions and failings of the Defendants, Plaintiff has retained the services of legal counsel and has necessarily contracted to pay attorneys' fees and costs for prosecuting this action. Plaintiff therefore requests an award of reasonable attorneys' fees and costs.

PRAYER FOR RELIEF

For these reasons set forth above, Radosti prays for the following relief:

i. That the Court enter judgment in Plaintiff's favor and against defendants.

ii. That the Court Order defendants to retroactively approve and reinstate Radosti to benefits under the LTD Plan and pay retroactive benefits under the LTD Policy and continue to pay all future benefits under the terms of the LTD Plan and Policy until such time as Radosti is no longer disabled within the meaning of the LTD Plan/Policy.

iii. That the Court Order equitable relief in the form of an injunction barring the Defendants from offsetting any SSDI benefits from Radosti's LTD claim or asserting any claim for recovery of any alleged overpayment as a result of his SSDI award and payments.

iv. That the Court Order Defendant MetLife to pay Radosti accrued prejudgment interest through the date of the judgment at the New York statutory rate for prejudgment interest.

v. That the Court Order equitable relief directing Citigroup to retroactively reinstate Radosti in any employee benefits including, but not limited to, medical, dental, prescription drug, retirement-401k, profit sharing plans, employee stock purchase plan, and stock option plan that were affected by the wrongful termination of Radosti as a Disabled employee entitled to LTD benefits under the Citigroup LTD Plan and to equitably allow Radosti to reverse certain elections that Radosti made concerning his other benefits that were not in his best interest and only made due to the wrongful termination of wrongful termination of his LTD benefits.

vi. That the Court order and award payment of reasonable attorney fees, expenses, and the costs of litigation incurred in this action pursuant to 29 U.S.C. § 1132(g).

vii. That the Court Order such other and further relief as the Court deems just and proper.

Dated: June 2, 2008
New York, New York

/s/

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The Citigroup Short Term Disability Plan and The Citigroup Long Term Disability Plan

Effective January 1, 2002

Plan Documents Amended and Restated as of January 1, 2005

The Citigroup Short Term Disability Plan and The Citigroup Long Term Disability Plan

About the Plan Documents

This document (the "Plan Documents") describes the terms and conditions of your coverage under the Citigroup Short Term Disability Plan and the Citigroup Long Term Disability Plan (each individually referred to as the "Plan" and collectively referred to as the "Plans"). Further details about your coverage under the Long Term Disability Plan can be obtained from the insurance contracts, which are also deemed to be part of the Plan Documents. Should there be any discrepancy between the provisions outlined in the Plan Documents and the related insurance contract(s) produced by the insurance companies, the provisions of the insurance contracts shall prevail. The Plans are governed by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), and both Plans are intended to comply with the requirements under ERISA.

As the Claims Administrators, the insurance companies are the named fiduciaries for adjudicating claims for benefits under the Plans, and for deciding any appeals of denied claims. The Claims Administrators shall have the authority, in their discretion, to interpret the terms of the Plans, to decide questions of eligibility for coverage or benefits under the Plans, and to make any related findings of fact. All decisions made by the Claims Administrators shall be final and binding on participants and beneficiaries to the fullest extent permitted by law.

If you are currently out of work for a disability that began prior to January 1, 2002 you are not covered under this document. MetLife is the Claims Administrator for any claims formerly administered under the Citibank Long Term Disability Plan or its predecessors.

If benefits are overpaid on your claim, you will be required to reimburse the Plan within 60 days, or the Plan will have the right to reduce future benefits until reimbursement is made. The Plan also has the right to recover such overpayments from your estate.

Citigroup reserves the right to terminate or amend this plan at anytime without notice.

Eligible Employees Covered by the Plans

Active full-time employees regularly scheduled to work 40 hours or more a week and active part-time employees regularly scheduled to work 20 hours or more a week, who work for a "participating company" as defined below, in the United States for a regular semimonthly or monthly paycheck are eligible ("Eligible Employees") to participate in the Plans.

Participating companies include American Health and Life Company; Citibank, N.A. and Participating Companies; CitiFinancial; Citigroup Corporate Center; Citigroup Global Corporate and Investment Bank; Global Wealth Management; Citigroup Investment Group; CitiStreet Institutional Division; CitiStreet Total Benefits Outsourcing Division; CitiStreet Retirement Services Division; Primerica Financial Services; National Benefit Life Insurance Company; and Travelers Life and Annuity. For purposes of the Plans, "Citigroup Global Corporate and Investment Bank" or "GCIB" means those businesses of Citigroup Global Markets Holdings Inc. and its subsidiaries, Citibank, N.A., and Citicorp whose employees collectively have been designated to come within or be managed by the Citigroup Global Corporate and Investment Bank or one of its participating companies; and, "Global Wealth Management" means those businesses of Citigroup Global Markets Holdings Inc. and its subsidiaries, Citibank, N.A., and Citicorp whose employees collectively have been designated to come within or be managed by Smith Barney or the Citigroup Private Bank.

For purposes of determining whether you are an Eligible Employee, you are an "active" employee if you are working for your employer doing all the material and substantial duties of your occupation at your usual place of business or some other location that your employer's business requires you to be or absent from work solely due to vacation days, holiday, scheduled days off or approved leaves of absence not due to disability.

You are not an Eligible Employee and can not participate in the Plans if:

- your compensation is not reported on a Form W-2 Wage and Tax Statement issued by a participating company;
- you are employed by a Citigroup subsidiary or affiliate that is not a participating company;
- you are engaged under an agreement that states you are not eligible to participate in the Plans;
- you are a non-resident alien performing services outside the United States; or
- you are classified by Citigroup as an independent contractor or consultant, or as being employed on a temporary basis.

If you are a US citizen or legal resident employed outside the United States in an expatriate classification, your eligibility will be determined in accordance with practices and procedures established under the Plans.

Definition of Total Compensation

With regard to certain commissioned participants under the Citigroup Short Term Disability Plan and all participants under the Long Term Disability Plan, benefit amounts are based on the participant's "total compensation" for the plan year in which an approved disability commenced. With respect to the current plan year, total compensation consists of (a) the annual rate of regular base pay based on scheduled work hours, excluding any shift differentials, as of July 1 of the

calendar year (the "Prior Year") which precedes the current plan year; (b) any commissions paid during the calendar year which precedes the Prior Year; (c) any non-annual cash bonuses paid during the calendar year which precedes the Prior Year; and (d) any annual bonus earned during the calendar year which precedes the Prior Year and that is paid in cash or in the form of an equity award under the Core Capital Accumulation Program during such calendar year or the Prior Year.

For example, the total compensation for the 2005 plan year includes:

- Base pay annualized as of July 1, 2004 (excluding shift differentials);
- Commissions paid from January 1 – December 31, 2003;
- Cash bonuses paid from January 1 – December 31, 2003 (excluding any annual bonus); and
- 2003 annual bonus (paid in 2003 and 2004).

If you were hired or rehired on or after July 1, 2004, yout total compensation is your annualized base pay as of your date of hire.

If you are a part-time employee, your total compensation will be calculated as follows:

Hourly rate of pay as of July 1, 2004 x 52 weeks x the number of hours scheduled to work.

If you are a Smith Barney financial consultant, in your first year of employment your total compensation is deemed to be $60,000. If you earned more than $60,000 in a previous brokerage firm in the prior year and want your insurance coverage to represent your prior earnings, you must provide a copy of your previous year's Form W-2 Wage and Tax Statement to Human Resources within 30 days after your hire date.

Termination and Amendment of Plans

Either Plan or both Plans may be amended, modified, suspended or terminated by the Plan Sponsor, with or without notice, in whole or in part at any time, subject to the applicable provisions of the insurance contracts.

Your rights upon termination or amendment of the plan are set forth in your Certificate of Insurance.

Statement of ERISA Rights

As a participant in this Citigroup Short Term Disability Plan and the Citigroup Long Term Disability Plan you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974. All plan participants are entitled to:

- Examine, without charge, at the Plan Administrator's office during normal working hours, all plan documents including insurance contracts and a copy of the latest annual report (Form 5500 series) filed by the Plans with the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Upon written request to the Plan Administrator, a copy of all plan documents including insurance contracts, updated summary plan descriptions and the latest annual report (Form 5500 series). The Plan Administrator who may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report, which the law requires the Plan Administrator of certain plans to provide to each plan participant. (Unless there are reasons beyond the control of the Plan Administrator, materials that you request should be received within 30 days. If they are not, you may file suit in a federal court. The court may require the Plan Administrator to pay up to $110 for each day's delay until the materials are received.)
- Receive a written explanation of the reasons why your claim for benefits has been denied in whole or in part and a review and reconsideration of your claim.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. These people are called fiduciaries, and they must act prudently and with the sole interests of you and other participants in mind.

No one, not even your employer, may terminate your employment or discriminate against you in order to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. When you are eligible to receive benefits under this plan, you must request a claim form or obtain instructions for submitting your claim telephonically or electronically, from the Plan Administrator. All claims you submit must be on the claim form or in the electronic or telephonic format provided by the Claims Administrator. If these forms or instructions are not available, you must provide a written statement of proof of loss. After you have completed the claim form or written statement you must submit it to the Plan Administrator.

Under the terms of the Plan, the Claims Administrator is the named fiduciary for adjudicating claims for benefits under the Plan, and for deciding any appeals of denied claims. The Claims Administrator shall have the authority, in its discretion, to interpret the terms of the Plan, to decide questions of eligibility for coverage or benefits under the Plan, and to make any related findings of fact. All decisions made by the Claims Administrator shall be final and binding on participants and beneficiaries to the fullest extent permitted by law.

The Claims Administrator has 45 days from the date it receives your claim for disability benefits, or 180 days from the date it receives a claim for any other benefit, to determine whether or not benefits are payable in accordance with the terms and provisions of the policy. The Claims Administrator may require more time to review your claim if necessary due to circumstances beyond its control. If this should happen, the Claims Administrator must notify you in writing that its review period has been extended for up to two additional periods of 30 days (in the case of a claim for disability benefits), or one additional period of 90 days (in the case of any other benefit). If this extension is made because you must furnish additional information, these extension periods will begin when the additional information is received. You have up to 45 days to furnish the requested information.

During the review period, the Claims Administrator may require a medical examination of the insured, at its own expense; or additional information regarding the claim. If a medical examination is required, the Claims Administrator will notify you of the date and time of the examination and the physician's name and location. It is important that you keep any appointments made since rescheduling examinations will delay the claim process. If additional information is required, the Claims Administrator must notify you, in writing, stating the information needed and explaining why it is needed.

If your claim is approved, you will receive the approved benefit from the Claims Administrator.

If your claim is denied, in whole or in part, you must receive a written notice from the Claims Administrator within the review period. The Claims Administrator's written notice must include the following information:

- The specific reason(s) the claim was denied.
- Specific reference to the policy provision(s) on which the denial was based.
- Any additional information required for your claim to be reconsidered, and the reason this information is necessary.
- In the case of any claim for a disability benefit, identification of any internal rule, guideline or protocol relied on in making the claim decision, and an explanation of any medically-related exclusion or limitation involved in the decision.
- A statement informing you of your right to appeal the decision, and an explanation of the appeal procedure, as outlined below.

Whenever a claim is denied, you have the right to appeal the decision. You (or your duly authorized representative) must make a written request for appeal to the Claims Administrator within 60 days (180 days in the case of any claim for disability benefits) from the date you receive the denial. If you do not make this request within that time, you will have waived your right to appeal.

Once your request has been received by the Claims Administrator, a prompt and complete review of your claim must take place. This review will give no deference to the original claim decision, and will not be made by the person who made the original claim decision. During the review, you (or your duly authorized representative) have the right to review any documents that have a bearing on the claim, including the documents which establish and control the Plan. Any medical or vocational experts consulted by the Claims Administrator will be identified. You may also submit issues and comments that you feel might affect the outcome of the review.

The Claims Administrator has 60 days from the date it receives your request to review your claim and notify you of its decision (45 days, in the case of any claim for disability benefits). Under special circumstances, the Claims Administrator may require more time to review your claim. If this should happen, the Claims Administrator must notify you, in writing, that its review period has been extended for an additional 60 days (or 45 days, in the case of any claim for disability benefits). Once its review is complete, the Claims Administrator must notify you, in writing, of the results of the review and indicate the plan provisions upon which it based its decision.

If you are improperly denied a welfare benefit in whole or part, you may file suit in a federal or state court. If you believe plan fiduciaries are misusing plan funds, or if you are discriminated against for asserting your rights, you may request assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees.

If you are successful, the court may order the person you have sued to pay these costs and fees, but if you lose you may be required to pay the costs and fees, for example, if the court finds that your claim is frivolous.

If you have any questions about your plan contact your Plan Administrator. If you have any questions about this statement, or your rights under ERISA you should contact the nearest office of the Employee Benefits Security Administration of the U.S. Department of Labor.

General Information

Employer Identification Number	52-1568099
Plan Numbers	Short Term Disability Plan # 529 Long Term Disability Plan # 530
Plan Sponsor	Citigroup Inc. 75 Holly Hill Lane Greenwich, CT 06830
Plan Administrator	Plans Administration Committee of Citigroup Inc. 125 Broad Street, 8th Floor New York, NY 10004
Claims Administrator	MetLife Contact information for the administrator is provided in the Supplement at the end of this document.
Plan Year	January 1 – December 31
Plan Type	Welfare Benefit
Plan Funding	Employer and Employee Contributions. The Plan may be funded through insurance contracts, a trust, and general assets of participating companies.
Agents for Service of Legal Process	Claims Administrators: Contact information for each Claims Administrator is in the Supplement. Plan Administrator: Citigroup Inc. General Counsel 399 Park Avenue, 3rd Floor New York, NY 10043

Continuation of Other Benefits

If you are on an approved Long Term Disability leave, call the Benefits Service Center about your rights to continue medical, dental, vision care, and/or spending account coverage. You will be billed directly for your regularly scheduled contributions in order to remain covered under these plans.

Your Basic Life Insurance will continue at no cost to you for the first 39 weeks of your Long Term Disability. After 39 weeks, you may convert your coverage to an individual policy by calling MetLife at (800) 523-2894. For the first 13 weeks of your disability (i.e. Short Term Disability), you may continue your Group Universal Life Insurance at active rates. Your premiums will be deducted from your Short Term Disability benefit payments. After 13 weeks, you will be billed directly for monthly premiums. Failure to pay premiums will result in the termination of your coverage.

Your Vision coverage will end after 13 weeks of disability, and you will no longer be eligible to contribute to a Dependent Care Spending Account. All Flexible Spending Accounts can be contributed to on an after-tax basis through the end of the plan year.

After 13 weeks of disability, your 401(k) contributions will cease. If you have an outstanding loan, you will have the option to pay the loan in full, default, or continue making monthly payments by personal check.

In applicable states, you will be paid for any earned and unused vacation days that were available to you at the time your disability began. You will begin earning vacation days on the day you return on a full-time basis. Any earned and unused floating holidays will be forfeited, except in the state of California.

If you return from your disability your medical, dental, and Group Universal Life Insurance will continue. Premium payments will resume through payroll deductions. You will have the option to enroll in the Vision Plan and the Flexible Spending Account. To enroll you must call the Benefits Service Center within 30 calendar days of your return to work.

You can also contribute to the 401(k) plan by contacting the Human Resources department. Any loan repayments will resume through payroll deductions.

If your employment is terminated while you are on Long Term Disability (52 weeks from your first day of Short Term Disability):

- Medical coverage may continue at active employee rates according to the schedule below.

Length of recognized Citigroup service as of week 52 from STD date	**Medical continuation period after week 52 (the termination of your employment)**
Less than 2 years	Six months
2 years to less than 5 years	Equal to length of service
5 years or more	As long as employee is disabled or has not reached his/her age limit for receiving LTD benefits

Note: The continuation period runs concurrent with COBRA (Consolidated Omnibus Budget Reconciliation Act), which allows employees and their covered dependents to continue health care coverage, at their own expense, under certain circumstances when coverage would otherwise end.

- Dental coverage may be continued after 52 weeks through COBRA.
- Health Care Spending Account coverage may be continued after 13 weeks through COBRA until the end of the plan year.
- Vision care may be continued after 13 weeks through Davis Vision.
- Basic life insurance is discontinued after 52 weeks, but it may be converted to an individual policy at higher rates.
- Group Universal Life (GUL) insurance is discontinued after 52 weeks, but the coverage is portable and may be converted to an individual policy at higher rates.

Other plans maintained by Citigroup may subrogate against the Citigroup LTD Plan and Claims Administrators without regard to the hold harmless rule.

Sick Days and Disability for Certain Legacy Employees

Sick time accrued by legacy employees of Citibank and The Associates was set aside in a "frozen sick bank" as of December 31, 2001. The time is expressed in days and will be kept separate from any time off allocation for 2002 and future years.

If you have a frozen sick bank, you can use the time to supplement your pay in these situations:

- If you have less than five years of service, you can use frozen sick bank days (frozen sick bank days cannot be prorated) to receive a total of 100% of base salary for up to 13 weeks while on an approved STD leave;
- If your total compensation is equal to or greater than $50,001, you do not elect LTD coverage, and you have an approved disability that continues beyond the 13-week Short Term Disability period, you can use your frozen sick bank days to receive 100% of base salary for up to 52 weeks from the first day of your approved disability leave;
- If you use your annual allocation of sick days and need additional time off for an illness or injury of less than a week (time away from work for an illness or injury that doesn't need to be reported to Citigroup's disability administrator), you may be able to use your frozen sick bank days. Note: this provision does not apply to CIB employees or employees of Emerging Markets and Asset Management.

Once your approved disability continues beyond 13 weeks and you have LTD coverage — either company paid or employee paid — you no longer can use frozen sick bank days to offset or supplement the 60% LTD coverage.

If your Total Compensation is equal to or greater than $50,001 per year and you do not elect employee paid LTD coverage, you can use your frozen sick time after 13 weeks of Short Term Disability until either you have used all your time or you reach week 52. After week 52, your employment will be terminated and you will forfeit all remaining sick days, just as you would if you terminated employment or retired.

The Citigroup Short Term Disability (STD) Plan

Citigroup provides Short Term Disability benefits coverage as a core benefit at no cost to covered employees. The Short Term Disability Plan is intended to provide income protection when an Eligible Employee is out of work due to injury, illness, or pregnancy.

Depending on the length of your service with Citigroup, the Short Term Disability Plan will generally provide payments ranging from 60% to 100% of your base salary for an approved disability leave of up to 13 weeks. If you were given credit for past service (either you were rehired or worked in the past for what is now a Citigroup company), your length of service will be adjusted accordingly.

Eligibility for STD Plan Benefits

Eligible Employees are eligible for benefits under the Short Term Disability Plan, if approved, for the duration of their Total Disability up to a maximum of 13 weeks, as long as they have completed one month of continuous service as an active employee.

STD Plan benefits become payable if you are an Eligible Employee with at least one month of continuous service as an active employee and you incur a "Total Disability" as defined below.

Total Disability

Total Disability means that due to a serious health condition, pregnancy, or injury, you are unable to perform the essential duties of your regular occupation for more than seven consecutive calendar days.

You are not considered to have a Total Disability if your illness, injury, or pregnancy only prevents you from commuting to and from work.

The elimination period is seven calendar days. Beginning the day after you satisfy the elimination period, salary continuation, if eligible and approved, will commence retroactive to your first scheduled work day. To qualify, you must be receiving appropriate care and treatment from a licensed health care provider on a continuing basis.

In no event will STD Plan benefits be payable to any employee who returns to work on a part-time basis (except for statutory benefits required under applicable state law).

Schedule of Benefits

For Eligible Employees (excluding commissioned Eligible Employees of GCIB and Smith Barney as defined below), the following schedule applies:

Years of Service	Weeks at 100% of Base Salary	Weeks at 60% of Base Salary	Total Weeks of Base Salary
Less than 1 Month	0	0	0
1 Month but less than 1 Year	1	12	13
1 Year but less than 2 Years	4	9	13
2 Years but less than 3 Years	6	7	13
3 Years but less than 4 Years	8	5	13
4 Years but less than 5 Years	10	3	13
5 Years or more	13	0	13

Commissioned Eligible Employees of GCIB and Smith Barney include Eligible Employees who are financial consultants, account executives, financial consultant associates, and investment associates paid on a commission basis by GCIB or Smith Barney, and may include other commissioned employees paid or historically paid through the Corporate and Investment Bank's payroll in accordance with procedures and policies established under the Plan.

For commissioned Eligible Employees of GCIB and Smith Barney, the following schedule applies:

Years of Service	Minimum Benefit (% of total compensation)	Plus Additional Benefit	Maximum Benefit (% of total compensation)
1 Month but less than 3 Years	60%	Commissions	100%
3 Years but less than 7 Years	70%	Commissions	100%
7 Years or more	80%	Commissions	100%

If you are a Smith Barney business analyst paid a monthly commission: You will receive STD benefits based on a recoverable draw against commissions.

Notwithstanding the foregoing, for employees paid on commission working in the Global Consumer Group: You will receive STD benefits based on a shadow salary of $24,000 (and not based on total compensation). If any commissions are generated while you are on an STD leave, they will be paid in addition to the STD benefit based on your length of service.

In addition, other employees paid on commission will receive STD benefits based on practices and procedures established under the Plan.

Offset for Benefits

Notwithstanding any provision to the contrary, Short Term Disability benefits may be offset by any monies owed to Citigroup and/or by any state benefits.

Taxation of Benefits

Short Term Disability benefits are taxable as ordinary income. Citigroup will withhold taxes on these benefits, and will also withhold deductions for other employee benefits.

Recurrent Disabilities

A recurrent disability is a Total Disability which results from the same cause as a prior claim for a Total Disability, during a specified period of time. You are able to claim benefits for an approved recurrent disability that occurs during the same period of disability without having to satisfy an additional 7-day elimination period.

Periods of disability for the same or related cause or causes will be considered the "same period of disability" if it recurs within 30 consecutive calendar days of your return to work from the initial approved Total Disability. (One work day is greater than four hours).

If you return to work and incur a Total Disability again with the same or related condition within a 30-day period, the balance of the STD benefits described under **Schedule of Benefits** will resume from the point you returned to work for a maximum of 13 weeks (for a reduced period to reflect the STD benefits paid prior to your return to work).

If either a recurrent disability or an unrelated disability occurs after you returned to work for more than 30 days following an initial disability, you may be eligible for additional STD benefits as summarized below

- Eligible Employees (excluding Eligible Employees of GCIB and Global Wealth Management) who experience an approved disability after returning to work for more than 30 days are eligible for up to an additional 13 weeks of STD benefits.

- Eligible Employees of GCIB and Global Wealth Management who experience an approved disability after returning to work for more than 30 days are eligible for up to an additional 13 weeks of STD benefits; provided; however, in no event shall the total period of STD benefits payable to such Eligible Employee during any calendar year exceed 26 weeks of STD benefits.

Statutory Disability Benefits

You may be eligible for statutory disability benefits if you work in California, Hawaii, New Jersey, New York, Puerto Rico, or Rhode Island.

To file a claim in the following three states, call ConnectOne at 1-800-881-3938 and choose the Disability option.

- California
- New Jersey
- New York

For Hawaii, call 800-779-6249.

For Puerto Rico, call 800-826-0547.

For Rhode Island, call 401-462-8466.

Exclusions

You will not receive Short Term Disability benefits for the following:

- A disability when your care is not supervised by a qualified physician;
- Injuries caused by war, international armed conflict, riot, or civil disobedience;
- Intentional self-inflicted injury;
- A disability that begins during an unapproved leave of absence;
- A disability that results from the commitment or attempted commitment of a felony, assault, battery, other public offense, or during incarceration; or
- A disability that results from cosmetic surgery, which is a surgical procedure that is not necessary to correct a sickness or injury.

Continuation of Other Benefits

While you are out of work on Short Term Disability, your coverage continues under other benefit plans in which you were participating. While receiving salary continuation, benefit premiums will be deducted from the payments made to you. If you go into an unpaid status, you will be billed for your regularly scheduled contributions to keep your benefits in force.

You will continue to earn vacation days during your Short Term Disability absence if you return to work full-time within thirteen weeks. If your absence exceeds thirteen weeks, you will not earn any vacation days during your disability.

Filing a Claim

You should file a Short Term Disability claim as soon as you know you will be out of work for more than seven calendar days due to a non-work related illness or injury (work related illness or injury is covered under Workers' Compensation).

To file a claim, call ConnectOne at (800) 881-3938; for text telephone service, dial (888) 807-9896. You will be referred to MetLife, the Claims Administrator for the STD Plan.

The Claims Administrator will provide you with the appropriate forms and can help you file for statutory disability benefits where applicable.

You should expect to provide the Claims Administrator with the following information when you call:

- Personal information such as name, SSN, date of birth, and current contact information;
- Employment information including your manager's name and contact information, your occupation, your last day worked (prior to your disability), and when you expect to return to work;
- Medical information including details on your illness or injury, dates of treatment, name and contact information for your physician(s).

After you report a claim, the Claims Administrator will contact you if any additional information is necessary for them to evaluate your claim. Once the Claims Administrator has collected and reviewed all of the relevant data, a case manager will approve or deny your claim. Benefits are approved for a fixed period of time, as determined by the case manager. The initial approval period is an estimate of how long it would take a regular person to recover from your disabling condition and may be adjusted based on medical information or other extenuating circumstances.

The case manager will notify both you and your manager of the Claims Administrator's decision regarding your claim. The Claims Administrator will specify a date that you are expected to return to work from an approved claim. If you are unable to return to work on the specified date, please contact the Claims Administrator immediately.

If Your Claim is Denied

If your claim for benefits is denied, you will receive a written notice from your Claims Administrator. For more information, see **Statement of ERISA Rights**.

Returning to Work

The case manager will work with you and your manager regarding any reasonable adjustments to your usual job or accommodations to your work site. Although the case manager will continue to follow-up with Citigroup and with your physician(s) for the duration of your claim, it is your responsibility to keep your manager and your Human Resources department informed of your progress. Citigroup may request that you provide a Fitness for Duty form before you return to work.

The Citigroup Long Term Disability (LTD) Plan

The Citigroup Long Term Disability Plan covers 60% of your annual Total Compensation through a group disability insurance policy. However, if your annual Total Compensation is $250,000 or more, based on your election, the LTD Plan will cover 60% of either (a) your Total Compensation up to a maximum of $500,000, or (b) $250,000 only. In no event shall the Monthly Benefit exceed $25,000 per month. Further details about your coverage under the Long Term Disability Plan can be obtained from the insurance contracts, which are also deemed to be part of the Plan Documents. Should there be any discrepancy between the provisions outlined in the Plan Documents and the related insurance contract(s) produced by the insurance companies, the provisions of the insurance contracts shall prevail.

Eligibility for LTD Plan Benefits

Eligible Employees are eligible for benefits under the Long Term Disability Plan so long as they satisfy any eligibility conditions under the related insurance contracts.

Participation and Total Compensation

In accordance with the terms and provisions of the applicable insurance contract, Citigroup provides LTD coverage as a core benefit at no cost to Eligible Employees whose Total Compensation is less than $50,001 per year, and Eligible Employees whose Total Compensation is $50,001 per year or greater must elect Long Term Disability coverage during the annual enrollment period (or within 31 days after your date of hire) and pay premiums via payroll deductions on an after-tax basis.

In no event will additional coverage under the Plan be provided through individual disability insurance policies.

Because an insurance carrier underwrites the Citigroup LTD Plan, you should refer to the Supplement at the end of this document in order to obtain more specific policy details for your coverage. The Supplement provides information on the following topics:

- Eligibility
- Effective Date of Coverage
- Definition of Disability
- Pre-Existing Conditions
- When Benefits Begin
- How Benefits Are Paid
- When Benefits End
- Waiver of Premium
- Recurrent Disabilities
- Family Survivor Benefits
- Other Insurance

- Exclusions and Limitations
- Filing A Claim
- Termination of Coverage

Evidence of Good Health

If your Total Compensation is greater than $50,001 per year, you must apply to become covered during the first annual enrollment period in which you are eligible to apply for coverage or, if you are a new hire and/or become eligible for benefits, you must apply to become covered during the first 31 days following your date of hire.

If you do not apply during this period, you will be required to provide evidence of good health, satisfactory to the insurance companies. Your coverage will become effective only when the insurance companies approve your evidence of good health.

You may be able to elect into the plan without providing evidence of good health if you incur one of the following qualified family status changes and elect coverage within 31 days of the change:

- you get married
- your marriage is dissolved through divorce or civil annulment
- you legally separate from your spouse
- your spouse dies
- you acquire a dependent child (by birth or otherwise)
- your spouse becomes employed or unemployed.

Participation in the LTD Plan is voluntary and you may cancel your coverage at any time.

To cancel your coverage or to enroll as a Late Entrant, call ConnectOne at (800) 881-3938; for text telephone service, call (888) 807-9896.

Elimination Period

In no event will benefits under the Citigroup LTD Plan commence before satisfaction of an "elimination period" as determined under the Supplement. If you incur an approved disability and return to work during your elimination period and you become disabled again with the same or related condition within 30 days of your return to work from the initial approved disability, you will not have to begin a new elimination period. However, the days worked during such temporary recovery will be added to your elimination period, and in no event will benefits under the Citigroup LTD Plan commence before satisfaction of such extended elimination period. If you return to work for more than 30 days, you will have to begin a new elimination period.

Conversion Privilege

You may be eligible to convert up to $3,000 of MetLife group coverage to a long term disability conversion plan when your employment with Citigroup ends, as long as your were enrolled in the LTD plan for the 12 months prior to your termination. The conversion policy only provides coverage for long term disabilities. Evidence of good health will not be required.

The format, benefits provided, premium, and other terms of the conversion coverage may differ from those provided under the Citigroup LTD Plan. You must contact the Benefits Service Center through ConnectOne to apply for the conversion plan within 31 days after your coverage under the Citigroup LTD Plan ends.

SUPPLEMENT A

The following Certificate from MetLife is the supplement that contains additional information about the coverage provided for different segments of the Citigroup population. The supplement is designed to provide information specific to the terms of the Claims Administrator. In cases where the information in the supplement differs from the information described previously, the information in the supplement prevails.

Supplement A shall cover all Eligible Employees who participate in the Citigroup Long Term Disability Plan. Coverage for these employees is provided by MetLife.

YOUR EMPLOYEE BENEFIT PLAN

LONG TERM DISABILITY

CITIGROUP INC.

Associates

Citi Global Relationship Bank

Citibank

Citibank Standard

CitiCard

CitiCapital

CitiDiners

Citigroup Corporate

CitiFinancial

CitiStreet

CitiStreet RSD

National Benefit Life

Primerica Financial Services

Travelers Life and Annuity

INTRODUCTION

We are pleased to present you with a Certificate of Insurance for group disability insurance. This Certificate states your benefits and summarizes some special services available to you at no additional cost. All of us appreciate the financial protection that group benefit plans provide in the event of illness or injury. Group disability insurance is an especially important benefit since it replaces a reasonable portion of your income lost due to a disability.

Your Employer recognizes the value of your services and the impact your absence can have on the organization. Therefore your benefit plan has been designed with a goal of rehabilitation and return to work in mind. The plan offers financial incentives for returning to work, while still receiving a benefit.

The benefits outlined in this Certificate are the foundation for comprehensive managed disability services. These special services focus on your *abilities*, versus a disability, and are available to you at no additional cost. They are tailored to meet your individual needs and are designed to help you to return to work as soon as possible. Managed disability services may also coordinate with other benefit programs in which you participate.

Your comprehensive disability program includes:

Financial Incentives for returning to work.

Rehabilitation Program that focuses on vocational rehabilitation, which means identifying the necessary training, therapy, job modifications and accommodations that can help you return to work.

Early Assistance Program offering rehabilitation assistance both *before and after* you file a claim for Long Term Disability Benefits.

Social Security Assistance Program to help make the Social Security Insurance application and approval process easier for you.

Easy Claim Application Process that may be started simply by calling an "800" claims hotline. Initial submission of the claim should be made no later than 12 weeks following your original date of disability or as soon as reasonably possible thereafter.

This Certificate is in an easy-to-read format and we urge you to read it carefully. We also recommend you keep it with your other important records for future reference. If you have any questions about the Certificate or the benefits it provides, please contact your Employer.

MetLife®

Metropolitan Life Insurance Company
One Madison Avenue, New York, New York 10010-3690

CERTIFICATE OF INSURANCE
for the Employees of

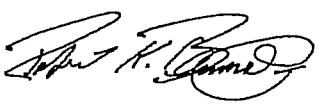
Citigroup Inc.
(called the Employer)

This is your Certificate of Insurance for Long Term Disability Insurance as long as you are insured under This Plan. The Group Policy and this Certificate may be changed or canceled according to the terms, conditions and provisions of the Group Policy. This Certificate describes the benefits under the Plan in effect as of January 1, 2002. Any prior Certificate relating to the coverage set forth herein is void.

MetLife in its discretion has authority to interpret the terms, conditions, and provisions of the entire contract. This includes the Group Policy, Certificate and any Amendments.

The Group Policy is delivered in and administered according to the laws of the governing jurisdiction.

Whenever a reference to "you" or "your" is made in this Certificate of Insurance, it means the covered Employee. Reference to "we", "us" or "our" means MetLife. Reference to "This Plan" means that part of the Employer's plan of employee benefits that is insured by MetLife.



Robert H. Benmosche
Chairman, President and Chief Executive Officer

Group Policy No.:1137000-2-G

This Plan contains a mandatory rehabilitation provision which may require you to participate in vocational training or physical therapy when appropriate.

Florida Residents: The benefits of the policy providing your coverage are governed primarily by the law of a state other than Florida.

Form G.24303-Cert.

For Texas Residents:

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call MetLife's toll-free telephone number for information or to make a complaint at

1-800-638-5433

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at

1-800-252-3439

You may write the Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
Fax # 512 - 475-1771

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim you should contact MetLife first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR CERTIFICATE: This notice is for information only and does not become a part or condition of the attached document.

Para Residentes de Texas:

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de MetLife para informacion o para someter una queja al

1-800-638-5433

Puede comunicarse con el Departmento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al

1-800-252-3439

Puede escribir al Departmento de Seguros de Texas
P.O. Box 149104
Austin, TX 78714-9104
Fax # 512 - 475-1771

DISPUTAS SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con MetLife primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU CERTIFICADO: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

Arkansas residents please be advised of the following:

IMPORTANT NOTICE

IF YOU HAVE A QUESTION CONCERNING YOUR COVERAGE OR A CLAIM, FIRST CONTACT YOUR GROUP EMPLOYER OR GROUP ACCOUNT ADMINISTRATOR. IF, AFTER DOING SO, YOU STILL HAVE A CONCERN, YOU MAY CALL METLIFE'S TOLL-FREE TELEPHONE NUMBER:

1-800-638-5433

IF YOU ARE STILL CONCERNED AFTER CONTACTING BOTH YOUR GROUP EMPLOYER AND METLIFE, YOU SHOULD FEEL FREE TO CONTACT:

ARKANSAS INSURANCE DEPARTMENT
CONSUMER SERVICES DIVISION
1200 WEST THIRD
LITTLE ROCK, ARKANSAS 72201-1904

California residents please be advised of the following:

IMPORTANT NOTICE

TO OBTAIN ADDITIONAL INFORMATION, OR TO MAKE A COMPLAINT, CONTACT METLIFE AT:

METROPOLITAN LIFE INSURANCE COMPANY
1 MADISON AVENUE
NEW YORK, NY 10010
ATTN: CORPORATE CONSUMER RELATIONS DEPARTMENT
1-800-638-5433

IF, AFTER CONTACTING METLIFE REGARDING A COMPLAINT, YOU FEEL THAT A SATISFACTORY RESOLUTION HAS NOT BEEN REACHED, YOU MAY FILE A COMPLAINT WITH THE CALIFORNIA INSURANCE DEPARTMENT AT:

CALIFORNIA DEPARTMENT OF INSURANCE
300 SOUTH SPRING STREET
LOS ANGELES, CA 90013
1-800-927-4357 (within California)
1-213-897-8921 (outside California)

Georgia residents please be advised of the following:

IMPORTANT NOTICE

The laws of the state of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence.

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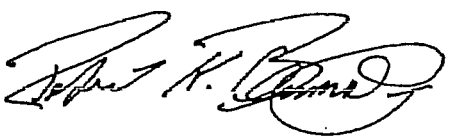
MetLife®

Metropolitan Life Insurance Company
One Madison Avenue, New York, New York 10010-3690

Endorsement

This Certificate is hereby endorsed as follows:

Wherever the word "spouse" or "spouse's" appear, the term "spouse or Domestic Partner" or "spouse's or Domestic Partner's" may be substituted respectively.



Robert H. Benmosche
Chairman, President and Chief Executive Officer

Form G.23000-END-23

PLAN HIGHLIGHTS

This Plan Highlights section is a summary of your Long Term Disability Benefits and provisions. See the rest of your Certificate for more information.

It is important to read the rest of your Certificate. It describes your benefits as well as any exclusions and limitations that apply to these benefits. Please read it carefully. You should talk with your Employer if you have any questions.

You will notice that some of the terms used in your Certificate begin with capital letters. These terms have special meanings. They are explained in this Certificate.

EMPLOYEE ELIGIBILITY

Eligible Employee: a person who is employed and paid for services by the Employer:

1. to work for the number of hours each week as determined by the Employer;
2. at the Employer's location; and:
   - **a.** is paid via the PeopleSoft payroll system if not located in Puerto Rico; or
   - **b.** is located in Puerto Rico, regardless of payroll system.

Class I: All Eligible Employees earning $50,000.00 or less.

Class II: All Eligible Employees earning at least $50,001.00, up to and including $149,999.99.

Class III: All Eligible Employees earning $150,000.00, up to and including $300,000.99.

Class IV: All Eligible Employees earning $300,001.00, up to and including $500,000.00.

If you do not have regular work hours you will be an Eligible Employee if you have worked at least an average of the required number of hours a week for your job during the preceding 12 calendar months (or during your period of employment if less than 12 months).

Employer includes Citigroup Inc. and each Citigroup Business Unit.

Eligibility Waiting Period:

Active Employees on and after January 1, 2002: None

Eligibility Date: January 1, 2002 or the date you become an Eligible Employee, whichever is later.

Citigroup Business Unit means one of the following: Associates; Citi Global Relationship Bank; Citibank; Citibank Standard; CitiCapital; CitiCard; Citi Diners; CitiFinancial; CitiStreet; CitiStreet RSD; National Benefit Life; Primerica Financial Services; or Travelers Life and Annuity.

PeopleSoft means a payroll system used by the Employer.

LONG TERM DISABILITY BENEFITS

Monthly Benefit: 60% of the first $500,000 of your Predisability Earnings, reduced by Other Income Benefits. Other Income Benefits are described in Section B. of Long Term Disability Benefits.

Maximum Monthly Benefit: $25,000

Minimum Monthly Benefit: 10% of the Monthly Benefit before reductions for Other Income Benefits or $100, whichever is greater. The Minimum Monthly Benefit will not apply if you are in an Overpayment situation or are receiving income from employment.

Elimination Period:

13 weeks of short term disability benefits.

Maximum Benefit Duration: The duration shown below:

Age on Date Disability Starts	Maximum Benefit Duration
Less than 60	To age 65
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

Work Incentive:

Work while Disabled: No offset for employment earnings during the first 12 months after you have satisfied your Elimination Period. However, your Monthly Benefit may be reduced if the total income you are receiving exceeds 80% of your Predisability Earnings.

Survivors Benefit: A lump sum equal to 6 times the Monthly Benefit before reductions for Other Income Benefits.

Conversion Privilege: If your coverage under This Plan terminates, you may be eligible to convert to a long term disability conversion plan.

LIMITATIONS

Limitation for Pre-existing Conditions: Coverage for Pre-existing Conditions begins 12 months after your Effective Date of coverage.

Limitations For Disabilities Due to Particular Conditions

Limitation for Disability due to Mental or Nervous Disorders or Diseases, and Drug, Alcohol or Substance Abuse or Dependency:

24 Monthly Benefits in your lifetime, or the Maximum Benefit Duration, whichever is less. Benefits may be paid beyond 24 months as described in the provision, subject to certain requirements. Benefits for Drug, Alcohol or Substance Abuse or Dependency will end if you cease or refuse to participate in a rehabilitative program.

CONTRIBUTIONS

If you are in Class I, your Long Term Disability Benefits are paid for by your Employer.

If you are in Class II, III or IV your Long Term Disability Benefits are paid for by you.

BENEFITS CHECKLIST

In order to receive benefits under This Plan, you must provide to us at your expense, and subject to our satisfaction, all of the following documents. These are explained in this Certificate. Initial submission of these documents should be made no later than the 12th week following your original date of disability.

- ✓ Proof of Disability.
- ✓ Evidence of continuing Disability.
- ✓ Proof that you are under the Appropriate Care and Treatment of a Doctor throughout your Disability.
- ✓ Information about Other Income Benefits.
- ✓ Any other material information related to your Disability which may be requested by us.

Form G.24303-A

EMPLOYEE ELIGIBILITY

Active Employee

You are an Active Employee if you:

1. are an Eligible Employee working for the Employer doing all the material duties of your occupation at (i) your usual place of business; or (ii) some other location that your Employer's business requires you to be;

2. are a citizen or legal resident of the United States or Canada; and

3. are not a temporary or seasonal employee.

You will be deemed an Active Employee if:

1. you meet the above conditions; and

2. you are absent from work solely due to vacation days, holidays, scheduled days off, or approved leaves of absence not due to Disability.

Effective Date of Coverage

If you are a member of Class I, you will be covered on the later of the following dates:

1. your Eligibility Date as described in Plan Highlights; or

2. the date you meet the Active Employee requirements.

If you are a member of Class II, III or IV, you may participate in the benefit plan which your Employer has established. Under such plan, there are rules regarding the time frames during which you may make a request to be covered under This Plan as set forth below. Your Employer can provide you with more information regarding the benefits plan. In order to become covered under This Plan, you must make a written request to the Employer on the benefits enrollment form furnished by the Employer.

Requests to be covered under This Plan may be made without Evidence of Good Health:

1. during the thirty-one day period following your Eligibility Date; or

2. within thirty-one days of a Qualifying Event; or

3. during any subsequent annual enrollment period, as designated by the Employer and reported to you, following your Eligibility Date.

Requests for changes in your benefits under This Plan may be made without Evidence of Good Health:

1. during the annual enrollment period, as designated by the Employer and reported to you; or

2. within thirty-one days of a Qualifying Event.

If you make a request to be covered under This Plan or to change your benefits under This Plan at any other time, Evidence of Good Health must be given to us.

"Evidence of Good Health" is a statement providing your medical history. We will use this statement to determine your insurability under This Plan. This statement must be provided to us at your expense.

If you make a request to be covered under This Plan within thirty-one days of your Eligibility Date, you will become covered on the later of the following dates:

1. your Eligibility Date as described in Plan Highlights; or

2. the date you meet the Active Employee requirements.

If you make a request to become covered under This Plan, or if you make a request for changes in your benefits under This Plan, within thirty-one days of a Qualifying Event, you will become covered, or the change(s) in benefits will become effective, on the later of the following dates:

1. the first day of the month following the date of your request; or

2. the date you meet the Active Employee requirements.

If you make a request to become covered under This Plan, or if you make a request for changes in your benefits under This Plan, during an annual enrollment period, you will become covered, or the change(s) in benefits will become effective, on the later of:

1. the first day of the calendar year following the annual enrollment period; or

2. the date you meet the Active Employee requirements.

If you make a request to be covered under This Plan at any other time, you will become covered on the later of:

1. the first day of the month following the date we approve your Evidence of Good Health; or

2. the date you meet the Active Employee requirements.

If you were eligible for coverage under the prior plan but did not elect to be covered under the prior plan, you will be required to provide Evidence of Good Health satisfactory to us. Your coverage will become effective when we approve your Evidence of Good Health.

"Qualifying Event" means a change in your family status due to one or more of the following events:

1. marriage;

2. birth, adoption or placement for adoption of a dependent child;

3. divorce, legal separation or annulment;

4. death of a dependent.

Continuity of Coverage upon Replacement of Plans

In order to prevent a loss of coverage because of a transfer of insurance carriers, This Plan will provide coverage for you if:

1. you were covered under the prior carrier's plan that This Plan replaced at the time of transfer; and

2. you are an Eligible Employee and you are not an Active Employee.

Coverage will only be provided if the required payment toward the cost of your coverage is made to us.

The benefit payable will be that which would have been paid by the prior carrier had coverage remained in force, less any benefit for which the prior carrier is liable.

Changes in Amount of Monthly Benefit

The amount of your Monthly Benefit may change as a result of a change in your earnings or class. The new Monthly Benefit amount:

1. will take effect on the January 1st following the change; and

2. will apply only to Disabilities commencing thereafter.

However, if you are not an Active Employee on the above date, the new Monthly Benefit amount will take effect on the date you are again an Active Employee.

Form G.24303-B

LONG TERM DISABILITY BENEFITS

A. Monthly Benefit

You will be paid a Monthly Benefit, in accord with Plan Highlights, if we determine that:

1. you are Disabled; and

2. you became Disabled while covered under This Plan.

Benefits will begin to accrue on the date following the day you complete your Elimination Period. Payment of the Monthly Benefit will start at the end of the month after completion of the Elimination Period. Subsequent payments will be made each month thereafter. Payment is based on the number of days you are Disabled during each one month period.

Contributions are not required for the time that Monthly Benefits are payable.

After we determine that you are Disabled, your Monthly Benefits will not be affected by:

1. termination of This Plan;

2. termination of your coverage; or

3. any plan change that is effective after the date you became Disabled.

When Benefits End

Monthly Benefits will end on the earliest of the following dates:

1. the end of the Maximum Benefit Duration;

2. the end of the period specified in the Limitation for Disabilities Due to Particular Conditions;

3. the date you are no longer Disabled;

4. the date you fail to provide us with any of the information listed in Plan Highlights under Benefits Checklist;

5. the day you die;

6. the date you fail to attend a medical examination requested by us as described in Medical Examination.

If you are a member of Class I, your Monthly Benefits will end on the date you cease or refuse to participate in a Rehabilitation Program approved by your Doctor as described in Work Incentive.

Definition of Domestic Partner

"Domestic Partner" means each of two people in a Domestic Partnership. A "Domestic Partnership" is formed by two people, one whom is an Employee of the Employer:

1. who are each eighteen years of age or older, neither of whom:

   a. is married; nor

   b. is related by blood in a manner that would bar their marriage in their place of residence; nor

   c. has had another Domestic Partner within the prior 6 months; and

2. who have submitted to the Employer:

   a. an enrollment form completed by the Employee, requesting coverage for the other person as a Domestic Partner; and

   b. an affidavit which indicates an exclusive mutual commitment;

      i. to share the responsibility for each other's welfare and financial obligations;

      ii. which has existed for at least 6 months prior to the date of application for benefits under This Plan on account of the Domestic Partner;

      iii. which is expected to last indefinitely; and

c. proof of maintenance of the same residence for at least 6 months prior to the date of application for benefits under This Plan on account of the Domestic Partner; and

d. evidence of joint responsibility for basic financial obligations including two or more of the following:

   i. a joint mortgage or lease;

   ii. designation of the Domestic Partner as beneficiary for life insurance or retirement benefits;

   iii. joint wills or the designation of the Domestic Partner as executor and/or primary beneficiary;

   iv. designation of the Domestic Partner as durable power of attorney or health care proxy;

   v. ownership of a joint bank account, joint credit cards or evidence of other joint financial responsibility; and

   vi. other proof to establish economic interdependence.

The Employer will review the affidavit and proof and determine if the request to cover the person as a Domestic Partner is acceptable.

The Employer will inform the Employee of its decision.

Elimination Period

Your Elimination Period begins on the day you become Disabled. It is a period of time during which no benefits are payable. Your Elimination Period is shown in Plan Highlights. You must be under the continuous care of a Doctor during your Elimination Period. You may temporarily recover from your Disability during your Elimination Period. If you then become Disabled again due to the same or related condition, you may not have to begin a new Elimination Period.

Temporary Recovery During Your Elimination Period

If you return to work for 30 days or less during your Elimination Period, those days will count towards your Elimination Period. However, if you return to work for more than 30 days before satisfying your Elimination Period, you will have to begin a new Elimination Period.

Temporary Recovery means you cease to be Disabled. During a period of Temporary Recovery you will not qualify for any change in coverage caused by a change in any of the following:

1. the rate of earnings used to determine your Predisability Earnings; or

2. the terms, provisions, or conditions shown in your Certificate of Insurance.

Definition of Disability

If you are a member of Class I, "Disabled" or "Disability" means that, due to sickness, pregnancy or accidental injury, you are receiving Appropriate Care and Treatment from a Doctor on a continuing basis; and

1. during your Elimination Period and the next 24 month period, you are unable to earn more than 80% of your Predisability Earnings or at your Own Occupation for any employer in your Local Economy; or

2. after the 24 months period, you are unable to earn more than 60% of your Predisability Earnings from any employer in your Local Economy at any gainful occupation for which you are reasonable qualified taking into account your training, education, experience and Predisability Earnings.

If you are a member of Class II, "Disabled" or "Disability" means that, due to sickness, pregnancy or accidental injury, you are receiving Appropriate Care and Treatment from a Doctor on a continuing basis; and

1. during your Elimination Period and the next 60 month period, you are unable to earn more than 80% of your Predisability Earnings at your Own Occupation for any employer in your Local Economy; or

2. after the 60 month period, you are unable to earn more than 60% of your Predisability Earnings from any employer in your Local Economy at any gainful occupation for which you are reasonable qualified taking in to account your training, education, experience and Predisability Earnings.

If you are a member of Class III or IV, "Disabled" or "Disability" means that, due to sickness, pregnancy or accidental injury, you are receiving Appropriate Care and Treatment from a Doctor on a continuing basis and you are unable to earn more than 80% of your Predisability Earnings at your Own Occupation from any employer in your Local Economy.

Your loss of earnings must be a direct result of your sickness, pregnancy or accidental injury. Economic factors such as, but not limited to, recession, job obsolescence, paycuts and job-sharing will not be considered in determining whether you meet the loss of earnings test.

For an employee whose occupation requires a license, "loss of license" for any reason does not, in itself, constitute Disability.

"Appropriate Care and Treatment" means medical care and treatment that meet all of the following:

1. it is received from a Doctor whose medical training and clinical experience are suitable for treating your Disability;

2. it is necessary to meet your basic health needs and is of demonstrable medical value;

3. it is consistent in type, frequency and duration of treatment with relevant guidelines of national medical, research and health care coverage organizations and governmental agencies;

4. it is consistent with the diagnosis of your condition; and

5. its purpose is maximizing your medical improvement.

"Doctor" means a person who: (i) is legally licensed to practice medicine; and (ii) is not related to you. A licensed medical practitioner will be considered a Doctor:

1. if applicable state law requires that such practitioners be recognized for the purposes of certification of disability; and

2. the care and treatment provided by the practitioner is within the scope of his or her license.

"Own Occupation" means the activity that you regularly perform and that serves as your source of income. It is not limited to the specific position you held with your Employer. It may be a similar activity that could be performed with your Employer or any other employer.

"Local Economy" means the geographic area surrounding your place of residence which offers reasonable employment opportunities. It is an area within which it would not be unreasonable for you to travel to secure employment. If you move from the place you resided on the date you became Disabled, we may look at both that former place of residence and your current place of residence to determine local economy.

Work Incentive

While you are Disabled, you are encouraged to work or participate in a Rehabilitation Program during your Elimination Period or while Monthly Benefits are being paid to you.

When you work while Disabled, you will receive the sum of the following amounts:

1. your Monthly Benefit; and

2. the amount of your earnings for working while Disabled.

During the 12 month period following your Elimination Period, your Monthly Benefit will be reduced if the total amount you receive from the above sources and Other Income Benefits exceeds 100% of your Predisability Earnings. Your Monthly Benefit will be reduced by that portion of the amount you receive which exceeds 100% of your Predisability Earnings.

After the 12 month period described above, your Monthly Benefit will be reduced by 50% of your earnings from working while Disabled. Your Monthly Benefit will be further reduced if the total amount you receive from the above sources and Other Income Benefits exceeds 80% of your Predisability Earnings. Your Monthly Benefit will be reduced by that portion of the amount you receive which exceeds 80% of your Predisability Earnings.

If your Monthly Benefit is reduced as a result of your receiving earnings from any work or service while Disabled, the Minimum Monthly Benefit will not apply.

"Rehabilitation Program" means:

1. a return to active employment by you on either a part-time or full-time basis in an attempt to enable you to resume gainful employment or service in an occupation for which you are reasonably qualified taking into account your training, education, experience and past earnings; or

2. participating in vocational training or physical therapy. This must be deemed by one of our rehabilitation coordinators to be appropriate.

Predisability Earnings

"Predisability Earnings" means the amount of your gross salary or wages from your Employer as of the day before your Disability began. This amount is updated each January 1st, and is calculated on a yearly basis in the previous July.

This will include:

1. commissions paid from the prior calendar year; and
2. bonuses paid in the prior calendar year (excluding annual incentive bonus paid in February of the prior year);
3. annual incentive bonus paid in February of the current year for the prior year's performance;
4. salary paid from the prior calendar year, including contributions you make through a salary reduction agreement with your Employer to any of the following:
   a. an Internal Revenue Code (IRC) Section 401(k), 403(b) or 457 deferred compensation arrangement;
   b. an executive nonqualified deferred compensation arrangement; and
   c. amounts contributed to your fringe benefits according to a salary reduction agreement under an IRC Section 125 plan.

Predisability Earnings do not include:

1. awards;
2. overtime pay;
3. your Employer's contributions on your behalf to any deferred compensation arrangement or pension plan; or
4. any other compensation.

If you are an employee of Citibank, bonuses and overtime pay are not included.

If you do not have regular work hours, your Predisability Earnings are based on the average number of hours you worked per month during the preceding 12 calendar months (or during your period of employment if less than 12 months). In no event will the number of hours be more than 173 hours.

B. Reduction of Benefits - Other Income Benefits

Your Monthly Benefit is reduced by Other Income Benefits shown below. The Monthly Benefit payable to you:

1. will not be less than the amount shown in Plan Highlights under Minimum Monthly Benefit (except in the case of an Overpayment or while receiving work earnings);

2. will not be further reduced due to cost-of-living increases payable under Other Income Benefits after the correct reduction has been determined;

3. will not be reduced by any reasonable attorney fees included in any award or settlement; and

4. will not be reduced by any sources other than those shown below.

If you receive Other Income Benefits in a lump sum instead of in monthly payments, you must provide to us satisfactory proof of the breakdown of: (i) the amount attributable to lost income; and (ii) the time period for which the lump sum is applicable. If you do not provide this information to us, we may reduce your Monthly Benefit by an amount equal to the Monthly Benefit otherwise payable. We will reduce the Monthly Benefit each month until the lump sum has been exhausted. However, if we are given proof of the time period and amount attributable to lost income, we will make a retroactive adjustment.

List of Sources of Other Income Benefits

1. **Federal Social Security Act, Railroad Retirement Act, Canada Pension Plan, or any provincial pension or disability plan, or the Canada Old Age Security Act**

   a. benefits that you receive because of your disability or retirement will be counted; and

   b. benefits available with respect to your spouse and dependents (regardless of marital status or their place of residence) because of your disability or retirement will be counted. If you are divorced or legally separated, benefits paid directly to your dependents and not taken into constructive receipt by you will not be counted.

   Your Monthly Benefit will not be payable unless:

   1. you provide proof that you have applied for Social Security disability benefits;

   2. you have signed the Reimbursement Agreement which confirms that you will repay all Overpayments; and

   3. you have signed the form authorizing the Social Security Administration to release information on awards directly to us.

   Your Monthly Benefit may be reduced once you have received approval or final denial of your claim from the Social Security Administration. For purposes of this section, final denial of your claim means that you have received a "Notice of Denial of Benefits" from an Administrative Law Judge.

   In any case, when you do receive approval or final denial of your claim from the Social Security Administration:

   1. your Monthly Benefit will be adjusted; and

2. you must promptly refund to us an amount equal to all Overpayments. If you do not promptly make such a refund to us, we may, at our option, reduce or offset against any future benefits payable to you, including the Minimum Benefit.

2. **Group Insurance Policies**

Group insurance policies will be counted if the Employer contributes towards them or makes payroll deduction for any of the following:

a. other group health insurance policies will be counted to the extent that they provide benefits for loss of time from work due to disability; and

b. a group life policy that provides installment payments for permanent total disability will be counted.

3. **Work Earnings** will not be used to reduce your Monthly Benefit except as described in Work Incentive.

4. **Employer's Retirement Plan**

Benefits for disability and/or retirement that you receive under the Employer's retirement plan will be counted to the extent they are attributable to the Employer's contributions.

Benefits under the Employer's retirement plan that are payable for disability is money which:

a. is payable under a retirement plan due to a disability as defined in that plan; and

b. does not reduce the amount of money which would have been paid as retirement benefits at the normal retirement age under the plan if the disability had not occurred. (If the payment does cause such a reduction it will be deemed a retirement benefit as defined below.)

Benefits under the Employer's retirement plan that are payable upon retirement is money which:

a. is payable under the Employer's retirement plan either in a lump sum or in the form of periodic payments;

b. is payable upon:

i. the later of age 62 or normal retirement age as defined in the retirement plan;

ii. early retirement age as defined in the retirement plan. (You must have voluntarily elected to receive payments prior to your normal retirement age); or

iii. disability as defined in the retirement plan. (You must have voluntarily elected to receive payment prior to your normal retirement age and such payment does reduce the amount of money which would have been paid at the normal retirement age under the plan if the disability had not occurred); and

NOTE: You will be considered to have voluntarily elected to receive payments if you file an application for benefits with the Retirement Plan and request the start of payments prior to your normal retirement age.

c. does not represent contributions made by you. Payments which represent your contributions are deemed to be received over your expected remaining life regardless of when such payments are actually received.

The Employer's Retirement Plan is a plan which provides retirement benefits to Employees and which is not funded wholly by Employee contributions. The term shall not include the following, regardless of the source of contributions:

a. profit sharing plans;

b. thrift or savings plans;

c. non-qualified plans of deferred compensation;

d. plans under IRC Section 401(k) or 457;

e. individual retirement accounts (IRA);

f. tax sheltered annuities (TSA) under IRC Section 403(b);

g. stock ownership plans; or

h. Keogh (HR-10) plans.

5. **No-fault Auto Laws**

Only the basic reparations portion for loss of income of a law providing for payments without determining fault in connection with automobile accidents will be counted. Supplemental disability benefits you buy under a no-fault auto law will not be counted.

6. **Other Programs or Plans including:**

a. a compulsory benefit program of any government which provides payment for loss of time from your job because of your disability will be counted;

b. any other group disability income plan, fund, or other arrangement, no matter what called, if the Employer contributes toward it or makes payroll deductions for it, will be counted; or

c. any sick pay or other salary continuation, other than vacation pay, paid to you by the Employer will be counted.

7. **Workers' Compensation or a Similar Law**

Periodic benefits and substitutes and exchanges for periodic benefits will be counted.

8. **Occupational Disease Laws**

9. **Maritime Maintenance & Cure**

10. **Individual Insurance Policies**

100% of Benefits payable under an individual disability policy sponsored by the Employer.

11. Third Party Recovery

The amount of recovery you receive for loss of income as a result of claims against a third party by judgment, settlement or otherwise.

12. Unemployment Insurance Law or Program

Exceptions to Other Income Benefits

Other Income Benefits will not include:

1. group credit or mortgage disability insurance benefits; or
2. early retirement benefits not taken into constructive receipt.

C. Supplemental Benefits

Survivors Benefit

If you die while you are receiving benefit payments under This Plan, your spouse or unmarried children under age 25 may be eligible for a lump sum Survivors Benefit.

The amount of the Survivors Benefit is equal to 6 times the Monthly Benefit before reductions for Other Income Benefits. The amount of Survivors Benefit payable is reduced by any Overpayment which we are entitled to recover.

We will pay the Survivors Benefit to your Eligible Survivor, if the following conditions are met:

1. you have completed your Elimination Period;
2. you are eligible to receive a Monthly Benefit at the time of death;
3. you have an Eligible Survivor; and
4. proof of your death is provided to us.

An Eligible Survivor is one of the following:

1. your surviving spouse; or
2. if there is no surviving spouse, your unmarried children or your spouse's unmarried children under age 25. The term children also includes adopted children and children placed for adoption until legal adoption. Payment will be divided into equal shares among the eligible children.

We will pay a Survivors Benefit to your Eligible Survivor on the date one month after the last Monthly Benefit payment was made before your death. However, if there is no Eligible Survivor on the date payment is due to be paid, no payment will be made.

Payment to a minor child may be made to an adult who submits proof satisfactory to us that he/she has assumed custody and support of the child.

Conversion Privilege

You may be eligible to convert to a long term disability conversion plan when your employment ends. This plan only provides coverage for long term disabilities. Evidence of Good Health will not be required. However, you must meet the following conditions:

1. you must have been covered under this Conversion Privilege, or a similar Conversion Privilege under a plan that This Plan replaced, for at least 12 months prior to the date your employment ends;

2. your coverage under This Plan must end as a result of termination of your employment with the Employer, other than as a result of retirement; and

3. you apply in writing and pay the first premium for the long term disability conversion plan within 31 days after your coverage under This Plan ends.

The maximum amount you may convert is $3,000.

This Conversion Privilege is not available to you if:

1. your coverage under This Plan ends for any of the following reasons:

   a. This Plan ends;

   b. This Plan is amended to exclude the class of Employees to which you belong;

   c. you no longer belong to a class of Employees eligible for coverage under This Plan;

   d. you retire; or

   e. you do not make a payment which is required by the Employer to the cost of This Plan.

2. you are Disabled under the terms of This Plan; or

3. you become covered under any other long term disability plan within 31 days after your coverage under This Plan ends.

The conversion coverage will become effective on the day after your coverage under This Plan ends. The format, benefits provided, premium, and other terms of the conversion coverage may differ from those provided under This Plan. We reserve the right to have the conversion coverage issued by another insurance company.

D. Temporary Recovery

Once benefits become payable under This Plan, you may Temporarily Recover from your Disability. If you become Disabled again due to the same or related condition, you may not have to begin a new Elimination Period.

Once you have satisfied your Elimination Period, a period of Temporary Recovery is your return to work for less than 6 months for each period of Temporary Recovery.

During the Temporary Recovery you will not qualify for any change in coverage caused by a change in any of the following:

1. the rate of earnings used to determine your Predisability Earnings; or

2. the terms, provisions, or conditions shown in your Certificate of Insurance.

If your recovery lasts longer than the Temporary Recovery period allowed, when you become Disabled again you will have to begin a new Elimination Period.

E. Concurrent Disability

If a new Disability occurs while Monthly Benefits are payable, it will be treated as part of the same period of Disability. Monthly Benefits will continue while you remain Disabled. They will be subject to both of the following:

1. the Maximum Benefit Duration; and

2. Limitations and Exclusions that apply to the new cause of Disability.

F. Limitations

Limitation for Pre-existing Conditions

You may be Disabled due to a Pre-existing Condition. No benefits are payable under This Plan in connection with that Disability unless your Elimination Period starts after you have been an Active Employee under This Plan for 12 consecutive months.

A Pre-existing Condition is an injury, sickness, or pregnancy for which you in the 3 months before your Effective Date:

1. received medical treatment, consultation, care, or services;

2. took prescription medications or had medications prescribed; or

3. had symptoms or conditions which would cause a reasonably prudent person to seek diagnosis, care, or treatment.

If you cannot satisfy the above limitation and you were covered under the plan that This Plan replaced at the time of transfer, benefits will be payable under This Plan. We will give consideration towards the continuous time you were covered under the prior plan and This Plan. If you then satisfy the above limitation, the maximum Monthly Benefit payable under This Plan will not exceed the lesser of (i) the Maximum Benefit under This Plan; and (ii) the maximum benefit under the prior plan.

Limitation For Disabilities Due to Particular Conditions

Limitation for Disability due to Mental or Nervous Disorders or Diseases, and Drug, Alcohol or Substance Abuse or Dependency

Monthly Benefits are limited to 24 months during your lifetime if you are Disabled due to:

1. alcohol abuse;

2. drug or substance addiction; or

3. Mental or Nervous Disorders or Diseases.

If your Disability is due to alcohol abuse, drug or substance addiction, we require you to participate in an alcohol, drug or substance addiction recovery program recommended by a Doctor. We will end Monthly Benefit payments as of the earliest of the period described above or the date you cease, refuse to participate, or complete such recovery program.

If you are confined in a Hospital or Institution for treatment at the end of the 24 month period, your Benefits will continue until the date you are discharged.

This limitation will not apply to a Disability resulting from:

1. schizophrenia;

2. bipolar disorder;

3. dementia; or

4. organic brain disease.

"Hospital or Institution" means a facility licensed to provide care and treatment for your condition. Rest homes, nursing homes, convalescent homes, homes for the aged, and facilities primarily affording custodial, educational, or rehabilitative care are not acceptable as hospitals or institutions under This Plan.

"Mental or Nervous Disorder or Disease" means a medical condition which meets the diagnostic criteria set forth in the most recent edition of the Diagnostic And Statistical Manual Of Mental Disorders as of the date of your Disability. A condition may be classified as a Mental or Nervous Disorder of Disease regardless of its cause.

In no event will Monthly Benefits be payable longer than the Maximum Benefit Duration shown in the Plan Highlights.

G. Exclusions

This Plan does not cover any Disability which results from or is caused by or contributed to:

1. war, insurrection, or rebellion;

2. active participation in a riot;

3. intentionally self-inflicted injuries or attempted suicide; or

4. committing a felony.

"Participation" means all forms of taking part in, except actions taken in defense of:

1. public or private property;

2. yourself; or

unless such actions are taken against persons seeking to maintain or restore law and order.

"Riot" means all forms of public violence, disorder or disturbance of the peace by three or more persons. It does not matter whether:

1. there was common intent; or

2. there was intent to damage any person or property, or to break the law.

Form G.24303-1

TERMINATION OF COVERAGE

This provision applies to you if you are not Disabled.

You will cease to be covered on the earliest of the following dates:

1. the date This Plan terminates;

2. the date you cease to be an Eligible Employee;

3. the date you stop making any required contributions;

4. the date you go on strike or are locked out; or

5. the date you are laid-off.

Approved Leave of Absence

Your Employer may continue your coverage for an approved leave of absence by paying the required premium payments. Coverage may continue until the earliest of:

1. the date the Employer stops paying the required premium;

2. the date the leave ends; or

3. the last day of the month in which your leave of absence begins.

In the event the leave qualifies under the Family and Medical Leave Act of 1993 (FMLA), the period may be extended for a period agreed to by you and your Employer. It may not exceed 12 weeks following the date the leave begins. Your Employer must continue to pay the required premium.

In Connecticut, the FMLA period can be up to 16 weeks in any 12-month period following the date the leave of absence begins.

Reinstatement of Coverage

If your coverage ends, you may become covered again as an Eligible Employee. Coverage is subject to the following:

1. If your coverage ends because you cease to be an Eligible Employee, and if you become an Eligible Employee again within 3 months, the Eligibility Waiting Period will be waived. You will not have to provide Evidence of Good Health.

2. If your coverage ends because you cease making the required contribution while on an approved Family Medical Leave Act (FMLA) leave of absence, and you become an Eligible Employee again within 31 days of the earlier of:

   a. the end of the period of leave you and your Employer agreed upon; or

   b. the end of the 12 week period following the date your leave began;

   the Eligibility Waiting Period will be waived and you will not have to provide Evidence of Good Health.

3. In all other cases, if your coverage ends because you fail to make the required contribution, you must provide Evidence of Good Health to become covered again.

4. If you become covered again as described in 1. and 2. above, the Pre-existing Condition Limitation will be applied as if there had been no gap in coverage.

Form G.24303-D

EXTENSION OF BENEFITS

This provision applies if your coverage ceases while you are Disabled.

During your Elimination Period your coverage will continue while you are continuously Disabled until the end of your Elimination Period. Benefits will begin after the end of your Elimination Period. Your coverage will continue in either of the following situations:

1. This Plan terminates; or

2. you cease to be an Eligible Employee but required payments are made to us.

Benefits are payable if your Disability began while coverage was in force and continues without interruption after termination.

Extension of benefits beyond the period coverage was in force is limited to the Maximum Benefit Duration. Extension of benefits is subject to all of the following:

1. your Elimination Period; and

2. payment of any required contributions; and

3. all other applicable provisions of This Plan.

Form G.24303-C

CLAIMS

Notice of Disability

Notify us of your Disability as soon as you are able.

To notify us you may call us directly. You may obtain this phone number from your Employer. You will be instructed on how to give proof of Disability. You will be required to answer all questions concerning your Disability.

If you do not receive statements or instructions within 15 days after you have notified us, you may submit your statement in a letter.

Proof of Disability

Provide proof of Disability within 3 months after the end of your Elimination Period.

No benefits are payable for claims submitted more than one year after the date of Disability. However, you can request that benefits be paid for late claims if you can show that:

1. it was not reasonably possible to give written proof of Disability during the one year period; and

2. proof of Disability satisfactory to us was given to us as soon as was reasonably possible.

Documentation

At your expense, you must provide documented proof of your Disability. Proof includes, but is not limited to:

1. the date your Disability started;

2. the cause of your Disability; and

3. the prognosis of your Disability.

You will be required to provide signed authorization for us to obtain and release medical and financial information, and any other items we may reasonably require in support of your Disability.

These will include but are not limited to:

1. proof of continuing Disability;

2. proof you have applied, or are not eligible, for Other Income Benefits. If you do not provide proof you have applied for Other Income Benefits, we may reduce your Monthly Benefit. The reduction will be based on our estimate of what you would be eligible to receive through proper and timely pursuit;

3. proof that you applied for Social Security disability benefits until denied at the Administrative Law Judge level; and

4. proof you have applied for Workers' Compensation benefits or benefits under a similar law. If you do not provide proof that you have applied for these benefits, we may reduce your Monthly Benefit.

The reduction will be based on our estimate of what you would be eligible to receive through proper and timely pursuit.

If you do not provide satisfactory documentation within 60 days after the date we ask for it, your claim may be denied.

Method of Payment

When we determine you are Disabled:

1. Monthly Benefits are paid at the end of the month in which you qualify for them. Such benefits will be paid on a monthly basis thereafter.

2. Benefits will be paid to you. However, benefits unpaid at your death will be paid to:

   a. your spouse, if living; otherwise

   b. your children, if living, divided equally;

   c. your estate. If benefits are payable to your estate, we may pay up to $1,500 to someone related to you by blood or by marriage whom we deem entitled to this amount. We will be discharged to the extent of any payment made in good faith.

3. Monthly Benefits due for a period of less than a month will be paid as a fraction of the Monthly Benefit payable, calculated as 1/number of days in the month.

Right To Recover Overpayments

We have the right to recover from you any amount that we determine to be an Overpayment. You have the obligation to refund to us any such amount. Our rights and your obligations in this regard are also set forth in the reimbursement agreement you are required to sign when you become eligible for benefits under This Plan.This agreement: (i) confirms that you will repay all Overpayments; and (ii) authorizes us to obtain any information relating to Other Income Benefits.

An Overpayment occurs when we determine that the total amount paid by us on your claim is more than the total of the benefits due under This Plan. This includes any Overpayments resulting from:

1. retroactive awards received from sources shown in the List of Other Income Benefits;

2. fraud; or

3. any error we make in processing your claim.

The Overpayment equals the amount we paid in excess of the amount we should have paid under This Plan. In the case of a recovery from a source other than This Plan, our Overpayment recovery will not be more than the amount of the recovery.

You have the right to appeal any Overpayment recovery.

An Overpayment also occurs when payment is made by us that should have been made under another group plan. In that case, we may recover the payment from one or more of the following:

1. any other insurance company;

2. any other organization; or

3. any person to or for whom payment was made.

We may, at our option, recover the Overpayment by:

1. reducing or offsetting against any future benefits payable to you or your survivors;

2. stopping future benefit payments (including Minimum Benefits) which would otherwise be due under This Plan. Payments may continue when the Overpayment has been recovered; or

3. demanding an immediate refund of the Overpayment from you.

Legal Actions

No legal action of any kind may be filed against us:

1. within the 60 days after proof of Disability has been given; or

2. more than three years after proof of Disability must be filed. This will not apply if the law in the area where you live allows a longer period of time to file proof of Disability.

Medical Examinations

We will have the right to have you examined at reasonable intervals by medical specialists of our choice. The examination will be at our expense. Failure to attend a medical examination or cooperate with the medical examiner may be cause for denial or suspension of your benefits.

Incontestability of Coverage

This Plan cannot be declared invalid after it has been in force for 2 years. It can be declared invalid due to non-payment of premium.

No statement of health used by any person to get coverage can be used to declare coverage invalid if the person has been covered under This Plan for 2 years. In order to use a statement of health to deny coverage before the end of 2 years, it must have been signed by the person. A copy of the signed statement must be given to the person or the person's beneficiary.

Assignment

You may not assign your benefits. This means that you may not give or transfer your benefits to anyone else.

Workers' Compensation

This Plan is not in lieu of, and does not affect, any requirement for coverage by Workers' Compensation Insurance or any government mandated temporary disability income benefits law.

Form G.24303-E

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SPECIAL SERVICES

SOCIAL SECURITY ASSISTANCE PROGRAM

If you become Disabled MetLife provides you with assistance in applying for Social Security disability benefits. Before outlining the details of this assistance, you should understand why applying for Social Security disability benefits is important.

Why You Should Apply For Social Security Disability Benefits

Both you and your Employer contribute payroll taxes to Social Security. A portion of those tax dollars are used to finance Social Security's program of disability protection. Since your tax dollars help fund this program, it is in your best interest to apply for any benefits to which you may be entitled. Your spouse and children may also be eligible to receive Social Security disability benefits due to your Disability.

There are several reasons why it may be to your financial advantage to receive Social Security disability benefits. Some of them are:

1. **Avoids reduced retirement benefits**

   Should you become disabled and approved for Social Security disability benefits, Social Security will freeze your earnings record as of the date Social Security determines that your disability has begun. This means that the months/years that you are unable to work because of your disability will not be counted against you in figuring your average earnings for retirement and survivors benefit.

2. **Medicare Protection**

   Once you have received 24 months of Social Security disability benefits, you will have Medicare protection for hospital expenses. You will also be eligible to apply for the medical insurance portion of Medicare.

3. **Trial Work Period**

   Social Security provides a trial work period for the rehabilitation efforts of disabled workers who return to work while still disabled. Full benefit checks can continue for up to 9 months during the trial work period.

4. **Cost of Living Increases Awarded by Social Security Will Not Reduce Your Disability Benefits**

   MetLife will not decrease your Disability benefit by the periodic cost of living increases awarded by Social Security. This is also true for any cost of living increases awarded by Social Security to your spouse and children.

   This is called a Social Security "freeze." It means that only the Social Security benefit awarded to you and your dependents will be used by MetLife to reduce your Disability benefit; with the following exceptions:

   a. an error by Social Security in computing the initial amount;

b. a change in dependent status; or

c. your Employer submitting updated earnings records to Social Security for earnings received prior to your Disability.

Over a period of years, the net effect of these cost of living increases can be substantial.

How MetLife Assists You in the Social Security Approval Process

As soon as you apply for Disability benefits, MetLife begins assisting you with the Social Security approval process.

1. Contact Prior to Application For Social Security Disability Benefits

Before you even apply for Social Security disability benefits. We will help you determine the best time to apply for Social Security disability benefits. A MetLife Case Management Specialist begins assisting you with the application process at that time. The Specialist personally contacts you by phone to explain, in detail, how to apply for Social Security disability benefits and the advantages of doing this. We provide you with a list of items needed by Social Security in order to complete your claim.

2. Assistance Throughout the Application Process

MetLife has a dedicated team of Social Security Specialists. These Specialists, many of whom have worked for the Social Security Administration, are also located within our Claim Department. They provide expert assistance upfront and help guide you through the application process.

3. Guidance Through Appeal Process by Social Security Specialists

Social Security disability benefits may be initially denied, but are often approved following an appeal. If your benefits are denied, our dedicated team of Social Security Specialists provide expert assistance on an appeal if your situation warrants continuing the appeal process. They guide you through each stage of the appeal process. These stages may include:

a. Reconsideration by the Social Security Administration

b. Hearing before an Administrative Law Judge

c. Review by an Appeals Council established within the Social Security Administration in Washington, D.C.

d. A civil suit in Federal Court

4. Social Security Attorneys and Vendors

Depending on your individual needs, MetLife may provide a referral to an attorney or vendor who specializes in Social Security law. The cost for these attorneys is deducted from the amount you must repay to us if the retroactive Social Security disability benefits you later receive result in MetLife having paid more Disability benefits than we should have paid.

EARLY INTERVENTION PROGRAM

The MetLife Early Intervention Program is offered to all covered Employees, and your participation is voluntary. The program helps identify early those Employees who might benefit from vocational analyses and rehabilitation services before they are eligible for Long Term Disability Benefits. Early rehabilitation efforts are more likely to reduce the length of your disability and help you return to work sooner than expected.

If you cannot work, or can only work part-time due to a disability, your Employer will notify MetLife. Our Rehabilitation Coordinators may be able to assist you by:

1. Reviewing and evaluating your disabling condition, even before a claim for Long Term Disability Benefits is submitted (with your consent);
2. Designing individualized return to work plans that focus on your *abilities*, with the goal of return to work;
3. Identifying local community resources;
4. Coordinating services with other benefit providers, including: medical carrier, short term disability carrier*, workers' compensation carrier, and state disability plans;
5. Monitoring return to work plans in progress and modifying them as recommended by the attending physician (with your consent).

Our assistance is offered at no cost to either you or your Employer.

* If you also have MetLife Short Term Disability coverage or Salary Continuance Plan Management, these services are provided automatically. Notification by your Employer is not necessary.

RETURN TO WORK PROGRAM

Goal of Rehabilitation

The goal of MetLife is to focus on Employees' **abilities,** instead of disabilities. This "abilities" philosophy is the foundation of our Return to Work Program. By focusing on what Employees **can do** versus what they can't, we can assist you in returning to work sooner than expected.

Incentives For Returning To Work

Your disability plan is designed to provide clear advantages and financial incentives for returning to work either full-time or part-time, while still receiving a Disability benefit. In addition to financial incentives, there may be personal benefits resulting from returning to work. Many Employees experience higher self-esteem and the personal satisfaction of being self-sufficient and productive once again. If it is determined that you are capable but you do not participate in the Return to Work Program, your Disability benefits may cease.

Vocational Rehabilitation Services

As a covered Employee you are automatically eligible to participate in our Return to Work Program. The Program focus is vocational rehabilitation, which means identifying the necessary training and therapy that can help you return to work. In many cases, this means helping you return to your former occupation,

although rehabilitation can also lead to a new occupation which is better suited to your condition and makes the most of your abilities.

There is no additional cost to you for the services we provide, and they are tailored to meet your individual needs. These services include, but are not limited to, the following:

1. **Vocational Analyses**

   Assessment and counseling to help determine how your skills and abilities can be applied to a new or a modified job with your Employer.

2. **Labor Market Surveys**

   Studies to find jobs available in your locale that would utilize your abilities and skills.

3. **Retraining Programs**

   Programs to facilitate return to your previous job, or to train you for a new job.

4. **On-Site Job Analyses**

   Analyses to determine what modifications may be made to maximize your employment opportunities.

5. **Job Modifications/Accommodations**

   Changes in your job or accommodations to help you perform the previous job or a similar vocation, as required of your Employer under the Americans With Disabilities Act (ADA).

6. **Training in Job Seeking Skills**

   Special training to identify abilities, set goals, develop resumes, polish interviewing techniques, and provide other career search assistance.

Rehabilitation Staff

The Case Management Specialist handling your claim will begin the rehabilitation process. You may be referred to our professional Rehabilitation staff that includes Registered Nurses and vocational rehabilitation coordinators. Registered Nurses might address how your medical condition impacts your ability to return to work. Vocational rehabilitation coordinators will focus on identifying how your abilities can be best applied to either your previous job or a new job.

These rehabilitation specialists will contact you personally. They will coordinate their activities with your medical carrier and/or attending physician for a broad understanding of your diagnosis, prognosis, and expected return to work date.

Rehabilitation Vendor Specialists

In many situations, the services of independent vocational rehabilitation specialists may be utilized. Services are obtained at no additional cost to you; MetLife pays for all vendor services. Selecting a rehabilitation vendor is based on:

1. Attending physician's evaluation and recommendations;

2. Your individual vocational needs; and

3. Vendor's credentials, specialty, reputation, and experience.

When working with vendors, you and your Doctor still maintain control and direction of the case.

ERISA INFORMATION

NAME OF THE PLAN

Citigroup Long Term Disability Plan

NAME AND ADDRESS OF EMPLOYER AND PLAN ADMINISTRATOR

Citigroup Inc.
1 Court Square, 15th Floor
Long Island City, New York 11120
(212) 816-8000

EMPLOYER IDENTIFICATION NUMBER AND PLAN NUMBER

52-1568099 530

TYPE OF PLAN

Employee Welfare Plan including:

Long Term Disability Benefits

TYPE OF ADMINISTRATION

The above listed benefits are insured by Metropolitan Life Insurance Company, ("MetLife").

AGENT FOR SERVICE OF LEGAL PROCESS

For disputes arising under the Plan, service of legal process may be made upon the Plan administrator at the above address. For disputes arising under those portions of the Plan insured by MetLife, service of legal process may be made upon MetLife at one of its local offices, or upon the supervisory official of the Insurance Department in the state in which you reside.

ELIGIBILITY FOR INSURANCE; DESCRIPTION OR SUMMARY OF BENEFITS

Your MetLife certificate describes the eligibility requirements for insurance provided by MetLife under the Plan. It also includes a detailed description of insurance provided by MetLife under the Plan.

PLAN TERMINATION OR CHANGES

The group policy sets forth those situations in which the Employer and/or MetLife have the right to end the policy.

The Employer reserves the right to change or terminate the Plan at any time. Therefore, there is no guarantee that you will be eligible for the benefits described herein for the duration of your employment. Any such action will be taken only after careful consideration.

Your consent or the consent of your beneficiary is not required to terminate, modify, amend, or change the Plan.

In the event your coverage ends in accord with the "Termination of Coverage" provision of your certificate, you may still be eligible to receive benefits. The circumstances under which benefits are available are

described in your MetLife certificate.

CONTRIBUTIONS

No contribution is required for Long Term Disability Benefits if you are in Class I.

You must make a contribution to the cost of Long Term Disability Benefits if you are in Class II, III or IV.

The total premium rate for insurance provided under the Plan by MetLife is set by MetLife.

PLAN YEAR

The Plan's fiscal records are kept on a Plan year basis beginning each January 1 and ending on the following December 31.

CLAIMS INFORMATION

Procedures for Presenting Claims for Benefits

All claim forms needed to file for benefits under the group insurance program can be obtained from the Employer who will also be ready to answer questions and to assist you or, if applicable, your Eligible Survivor in filing claims.

Claim Submission

For claims for disability benefits, the claimant must complete the appropriate claim form and submit the required proof as described in the "Claims" section of the certificate.

Claim forms must be submitted in accordance with the instructions on the claim form.

Initial Determination

After you submit a claim for disability benefits to MetLife, MetLife will review your claim and notify you of its decision to approve or deny your claim.

Such notification will be provided to you within a reasonable period, not to exceed 45 days from the date you submitted your claim; except for situations requiring an extension of time because of matters beyond the control of the Plan, in which case MetLife may have up to two (2) additional extensions of 30 days each to provide you such notification. If MetLife needs an extension, it will notify you prior to the expiration of the initial 45 day period (or prior to the expiration of the first 30 day extension period if a second 30 day extension period is needed), state the reason why the extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information or filed an incomplete claim, the time from the date of MetLife's notice requesting further information and an extension until MetLife receives the requested information does not count toward the time period MetLife is allowed to notify you as to its claim decision. You will have 45 days to provide the requested information from the date you receive the extension notice requesting further information from MetLife.

If MetLife denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will

describe the additional information needed and explain why such information is needed. Further, if an internal rule, protocol, guideline or other criterion was relied upon in making the denial, the claims decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that you may request a copy free of charge.

Appealing the Initial Determination

If MetLife denies your claim, you may appeal the decision. Upon your written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim. You must submit your appeal to MetLife at the address indicated on the claim form within 180 days of receiving MetLife's decision. Appeals must be in writing and must include at least the following information:

- Name of Employee
- Name of the Plan
- Reference to the initial decision
- An explanation why you are appealing the initial determination

As part of your appeal, you may submit any written comments, documents, records, or other information relating to your claim.

After MetLife receives your written request appealing the initial determination, MetLife will conduct a full and fair review of your claim. Deference will not be given to the initial denial, and MetLife's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review your appeal will not be the same person as the person who made the initial decision to deny your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny your claim. If the initial denial is based in whole or in part on a medical judgment, MetLife will consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination.

MetLife will notify you in writing of its final decision within a reasonable period of time, but no later than 45 days after MetLife's receipt of your written request for review, except that under special circumstances MetLife may have up to an additional 45 days to provide written notification of the final decision. If such an extension is required, MetLife will notify you prior to the expiration of the initial 45 day period, state the reason(s) why such an extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information, the time period from MetLife's notice to you of the need for an extension to when MetLife receives the requested information does not count toward the time MetLife is allowed to notify you of its final decision. You will have 45 days to provide the requested information from the date you receive the notice from MetLife.

If MetLife denies the claim on appeal, MetLife will send you a final written decision that states the reason(s) why the claim you appealed is being denied and references any specific Plan provision(s) on which the denial is based. If an internal rule, protocol, guideline or other criterion was relied upon in denying the claim on appeal, the final written decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that you may request a copy free of charge. Upon written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim.

Routine Questions

If there is any question about a claim payment, an explanation may be requested from the Employer who is usually able to provide the necessary information.

Discretionary Authority of Plan Administrator and Other Plan Fiduciaries

In carrying out their respective responsibilities under the Plan, the Plan administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

STATEMENT OF ERISA RIGHTS

The following statement is required by federal law and regulation.

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan administrator's office and at other specified locations, all Plan documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan administrator, all copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary Plan description. The Plan administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including the Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for denial. You have the right to have the Plan administrator review and reconsider your claim.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored in whole or in part, you have a right to know why

this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $110.00 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees.

If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

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FUTURE OF THE PLAN

It is hoped that the Plan will be continued indefinitely, but Citigroup Inc. reserves the right to change or terminate the Plan in the future. Any such action would be taken only after careful consideration.

The Board of Directors of Citigroup Inc. shall be empowered to amend or terminate the Plan or any benefit under the Plan at any time.